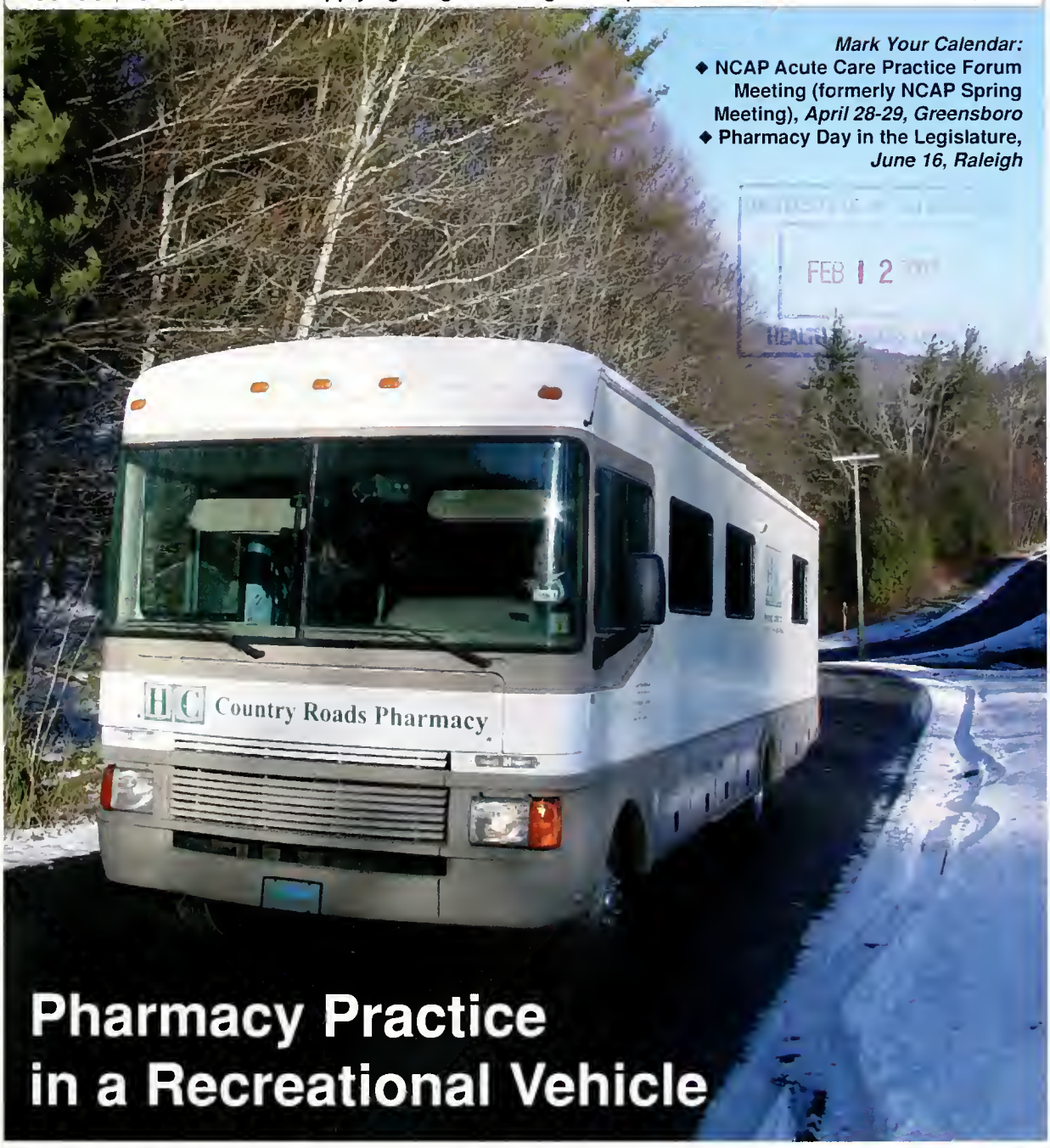
North Carolina Pharmacist

Volume 84, Number 1 ...applying drug knowledge to improve health Winter, 2004



Mark Your Calendar:

- NCAP Acute Care Practice Forum Meeting (formerly NCAP Spring Meeting), *April 28-29, Greensboro*
- Pharmacy Day in the Legislature, *June 16, Raleigh*

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North Carolina Pharmacist

Volume 84, Number 1 ...applying drug knowledge to improve health Winter, 2004

On the cover: *Country Roads Pharmacy. Special thanks to Steve Novak of Watauga Medical Center for serving as our "photographer on location" for this feature story.*

Inside

Fred Eckel
Executive Director

Improving the Structural Component of NCAP

NCAP started 2004 with a stable financial foundation. Thanks to Past President Jack Watts we have brought our staff to a level that we can support. Using part-time people to replace two full-time positions and outsourcing payroll and accounting, we saved over $50,000. The current staff have accepted some new responsibilities. We are looking at some cross-training of staff to cover different activities if the need arises. NCAP is now positioned to work on making the organization function efficiently and effectively.

The other activity that got the attention of Past President Watts was the Institute of Pharmacy. The financial underpinning to secure the building and remodel it will be in place this year. Our membership has responded well to the Pharmacy Network Foundation's challenge grant in 2003, allowing us to deposit $100,000 into the Endowment Fund's Building Fund. Another $50,000 challenge grant has been extended for 2004 by the Pharmacy Network Foundation, and we are well over halfway in meeting that challenge. We hope we can get the building refurbished in time to hold the 2004 House of Delegates and NCAP Awards Program here in late October before our Raleigh Convention October 25-27. We want to host a reception and open house for our members so we can all take pride in the home of North Carolina Pharmacy. Jack Watts provided the spark to get the building endowed so it would not be a financial drain on NCAP, but it was our members who fanned the flame. As we look back proudly at those pharmacists who in the 1940's and 50's made the Institute of Pharmacy a reality, I believe future generations will look back at what we've accomplished recently as a pivotal time in pharmacy's future. I wish I could thank each of you personally.

Under President Mark Gregory I look forward to stabilizing the organizational and policy-making structure of NCAP. I plan to put my energy for the next several years towards this end. As envisioned by the architects of NCAP, the Practice Forums play a key role in making sure that the special needs of each practice environment are being addressed by NCAP. This structural component of NCAP needs strengthening. Likewise, the policy development process of NCAP, which is done through the Council structure, needs to be improved. I plan to make this a priority for 2004 and 2005.

"NCAP is now positioned to work on making the organization function efficiently and effectively."

In today's world quick decisions need to be made if a professional organization expects to be able to influence change. The recently passed Medicare Drug Bill is evidence of that. When the content of the Bill was finalized Legislators and the public had only 48 hours to communicate and decide if they would support the Bill or not. Although this may be an extreme situation, it points out the need for NCAP to have a process in place to make quick decisions.

The Bill also demonstrated another problem in Pharmacy: "Is the glass half full or half empty?" By this I mean some pharmacy organizations saw payment for medication management services which was included in the legislation as worth supporting because it moved pharmacy towards its agenda of getting paid for cognitive services (glass is half full). Another organization thought the impact on current practice in their environment would be detrimental should the Medicare Drug Bill pass, so they came out opposed to the Bill (glass half empty). Regardless of what position was taken in the past, the Bill has now been passed, so we must find a way to make it work to the patients' advantage. Pharmacy, when united, is not the strongest lobby out there. When divided our influence is really compromised. The value of NCAP, as originally designed, was to deal with these different perspectives internally and then agree on a position to support as the profession. This may not be possible because pharmacy does not have an overriding mission that all pharmacists make as their highest professional responsibility. But, if we all want the same thing, then we should be able to find a way to agree to work together. If we really are committed as a profession in all practice settings, "to help people make the best use of medicines," then we ought to be able to cooperate on establishing positions, coordinate the promotion of that position, and improve the services patients receive from pharmacists. In North Carolina Pharmacy I believe we are closer to this reality today because of NCAP. As we work together to improve our structure and processes we will get further along in accomplishing this goal.

Thank you for your membership support. ❖

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Mark Gregory
President, NCAP

From the President:

The Year Ahead

The following is an excerpt of a message delivered at the 2003 NCAP Annual Convention.

Dear NCAP Members,

Thank you for the opportunity to serve as President of NCAP in 2004.

I have spent eleven years as a retail pharmacist prior to moving into corporate positions with Thrift Drug Company and now with Kerr Drug. At Kerr Drug our small pharmacy team, of which I am very proud, wears many hats overseeing government/regulatory affairs, privacy issues, pharmacy systems, PBM and managed care contracts, store support, pharmacy administration, and compliance and persistency programs. We are moving new initiatives along such as Kerr Drug Clinical Services, which includes a group of talented clinical coordinators and community pharmacy residents. I mention these things only to provide you with some background and to let you know that as President of NCAP I will serve as a pharmacist representing to the best of my ability all practice disciplines.

There are three things I would like to briefly address. First, the importance of being a member of a professional association. Second, NCAP's membership issues and finally, some thoughts about some of NCAP's strategies in the near future. Some of these comments may not seem appropriate for this audience because you are currently a member of NCAP, connected to issues, and have a passion about the profession's future. However, you can take these messages to those who have long been on the pharmacy sidelines and have not yet become involved.

Professional Association Membership

First, I would like to discuss why it is a critical and important time to become a member of this professional association, to stay current with pharmacy issues, and to network with your constituents. In community pharmacy, I attempt to stay current with issues affecting the profession. But, new issues are coming fast and furious. Recent items such as counterfeiting, re-importation, the new Medicare prescription benefit and patient privacy/security issues will impact again, and I say "impact again," the way we practice pharmacy. Why do I say, "Impact again?" Well, if you took a nap over the last five years and woke up today, you would find a significantly changed pharmacy environment with the following up's and downs:

Things that are up over that period of time:

- The demand for and financial compensation for pharmacists.
- The cost to dispense a prescription.
- Diverse opportunities for pharmacists. Pharmacists are now integrated into healthcare teams and valuable assets in the technology, teaching, benefit manager, and pharmaceutical industries.
- Utilization of medications is up. Certainly recognition of the healthcare value of prescription medications.
- The cost of the prescription benefit is up which is forcing employers to cost shift the benefit to employees or look at ways to get out of the benefit business.
- Direct to consumer drug advertising of new medications resulting in more public awareness but also escalating the drug budget.
- Discovery of new, effective and often costly medications is on the rise.

(continued on page 6)

- Pharmacy issues in the media have been heightened. You can't pick up the paper or turn on the news without pharmacy or prescription medications receiving some attention.
- Role of the pharmacy technician has increased, but I think we agree it still has some opportunity to grow.
- Prescriptions processed by a pharmacy benefit manager has increased. Five to eight years ago 10 percent of prescriptions were processed by a PBM and now 70 percent or greater are processed by a PBM.
- Legislative action and public policy dictating pharmacy practice has seen more activity, heightening the need to educate our legislators and public policy makers.
- Successful medication management programs (e.g., Asheville Project models) now have a greater presence.
- Mail order prescriptions were up eighty-eight percent from 1998 through 2002.
- Prescriptions received from across the border are up. It is reported last year ten million prescriptions were received by Americans from across the border.
- Counterfeit and adulterated drugs are up and attracting additional attention.
- And lastly worth noting are additional costs added to the system associated with regulatory items such as patient privacy and security.

Some items on a downward trend:

- The ability to spend time with our patients.
- Reimbursement levels for prescriptions in the private sector with PBM's.
- State budgets are stressed, placing pharmacy in the firing line with the State Employee and Medicaid prescription programs.
- Membership of professional associations.
- Lastly, the perception of pharmacy as a service profession.

This mix of up's and down's speaks to the bottom line: Our ability to control the destiny of the profession of pharmacy. With all pharmacy issues, this is the time to be involved and stay connected to pressing items. It is not only critical to be aware, but to be involved and network with other practitioners. NCAP is certainly a perfect platform to be our facilitator in this capacity.

NCAP Membership

The second issue I would like to briefly address is membership woes and what you can do to help. In 2000, NCAP had 2,170 members. Membership peaked in 2001 with a little over 2,300 members. In 2003, NCAP had 1,910 members and yet, during this same time, the number of licensed pharmacists in our State grew significantly. Let me note here that our problem is not any different than other professional associations with waning memberships. Our challenge is a membership issue combined with all of the pressing pharmacy issues mentioned above.

I do not have the ultimate answer to our membership woes. However, there are three categories of pharmacy practitioners in our state that I would like to take a moment to describe.

First, there are the seasoned practitioners. This may be you. You may have been an NCAP member for a number of years but for all kinds of reasons, you are not as involved with NCAP as you were before. Maybe because you are too busy or you are not sure how to be involved. Maybe because you're thinking, "I served my time." However, your experience and involvement are necessary for guidance. Please contact Fred Eckel or myself to see how you can get involved. One way to get involved is to rattle the cage of the next category of practitioners who you work alongside day to day.

These are the sideline practitioners, those pharmacists who have never participated or joined an association because they have found their professional comfort zone. As with all previous initiatives, this is a hard group to crack. As seasoned practitioners we need to minimally convince them to join NCAP, be on a list of contacts, stay in tune to issues, and be a pharmacy advocate.

The third group is our new practitioners. If this is you, you had better care; you are the future. I have seen past seasoned leaders who have been frustrated with the environment and have "taken their professional retirement package," and because of this, new young leaders are needed. Choose your spot and serve with a passion. Your voice will be heard and there are many opportunities. I work with some of these young pharmacy leaders at Kerr Drug on a daily basis and they are truly making a difference.

NCAP Infrastructure and Strategy

The third issue I would like to address as NCAP President is looking at a long-term strategy for financial stability and infrastructure for the Association. I recently headed up a staff review committee process to look at NCAP's current staffing and finances. The committee did make some changes, and difficult changes in staffing and outsourcing some tasks to streamline NCAP's operation. We now have a lean staff and owe them a great deal of appreciation because they also want to see our Association succeed. NCAP's Board has taken action to transfer the ownership and management of the NCAP Building to the Association's Endowment Fund. This is also another necessary move to garner some financial benefit and allow NCAP to focus on professional activities. NCAP is currently reaping some financial returns from these moves. We can consider this phase one. As it stands right now we are in a better financial position, allowing us to move into phase two.

Phase two, which I would initiate early in my presidency, is to look for opportunities to surround our core staff and add financially sensible positions to grow revenue and services within the Association. As the infrastructure strategically grows and becomes strong, so will the voice we can make for pharmacy. A great deal of merit for the current success of NCAP goes to our Executive Director, Fred Eckel, who now wears many new hats and has taken on some responsibilities he certainly did not see himself performing just six months ago. One part of our strategy is to create a

business infrastructure within the Association, which is managed closely and looks for other revenue opportunities. We need to find a way to get to those new revenue dollars to allow the Association to grow.

Please step forward and be a part of these changes. I look forward to moving the process as quickly as possible.

So, going forward, what do we need to do? To recap, we need to be:

- Financially sound with a strategic infrastructure.
- An advocate and baseline voice for the profession.
- A communicator and facilitator of current issues and innovation.

Recently, I gave a short presentation discussing how I got to where I am in my career and I included some lessons learned along the way. I think it is worth mentioning six of those lessons that all practitioners should keep in mind as we move NCAP forward.

1. Build a strong team and continue to develop.
2. Get involved. Don't sit on the sidelines. For some that may mean to volunteer time or donate money. Show initiative, learn along the way, and always be a pharmacy advocate.
3. Avoid WIFM syndrome. Stay away from "What's In It For Me" and challenge the thought process of "What's In It For My Profession."
4. Don't criticize the system - fix it. Juggle your priorities daily, break out of your comfort zone, and challenge others to break out of their comfort zone.
5. Keep quality in mind - don't take shortcuts.
6. Don't burn bridges - build bridges. We need to continuously network with our constituents.

Sincerely,
Mark Gregory, RPh
President, NCAP

2003 President's Club

NCAP would like to express its appreciation to the 2003 President's Club Members who made contributions to support the activities of the Association. We hope that you will support NCAP by making a tax-deductible contribution to the NCPhA Endowment Fund. Please forward to NCAP, 109 Church Street, Chapel Hill, NC 27516.

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Pharmacy Practice...

...in a Recreational Vehicle

Pharmacist Martha Lyon pilots a 34 foot motorhome/ mobile pharmacy through winding mountain roads to provide vital services for thousands of low income patients. The first of its kind, she established Country Roads Pharmacy to serve patients in rural areas surrounding Boone, NC. The mobile pharmacy is a service of the Hunger Coalition of Watauga County, a non-profit organization funded by donations and grants for indigent care.

by Marth Lyon

I've been a practicing pharmacist long enough to remember when hospital pharmacies were started in very small rooms, sometimes a closet. So while someone may think it would be impossible to have a pharmacy servicing over 500 clients in the bedroom of a recreational vehicle, it's much the same as where I began my practice.

There are approximately 35 "free pharmacies" in North Carolina doing much the same job that I do. While free pharmacies don't have to deal with third-party payers, credit card purchases, or handle any money as you would in a retail practice, we do have to screen potential clients for financial eligibility and educate them about how to access their VA or other medicine benefits. The only thing that makes my practice unique is that I drive my pharmacy to remote areas in the northern North Carolina Mountains: Allegheny, Ashe, Avery and Watauga counties, to be specific.

The name of the mobile pharmacy is Country Roads Pharmacy and it is owned and operated by the Hunger Coalition in Boone, North Carolina. The Hunger Coalition started a free pharmacy in 1995 for clients of Watauga County. It was supported by the United Way, which subsequently changed to the High Country United Way of Avery, Ashe and Watauga counties. When we opened our pharmacy services up to Ashe and Avery county residents, we soon realized that transportation was a huge barrier to accessing our services (we had one client who would walk to Boone from Beach Mountain to get her blood pressure medication). So was born the idea of a mobile pharmacy, which was encouraged and funded by the Kate B. Reynolds Charitable Trust in 1998. We purchased a 34 foot recreational vehicle and converted the back bedroom into our pharmacy. We use physician samples donated by the physicians and we have a small budget from various grants and

private donations to purchase medications. Our maiden run was made in August 1998 and well over 40 people met the pharmacy as it pulled into the Warrensville Blue Ridge Opportunity Commission parking lot. Our claim to fame is that we were the first mobile pharmacy in the United States.

Over the past five years, we have grown to an active client base of over 400 and we fill an average of 100 prescriptions per stop. We have adjusted our procedures over time in order to become as efficient as possible with the goal of serving the growing numbers of clients with the available resources. For example, clients have to get renewal prescriptions from their doctor as we do not have time to call an office for refill authorization. We also do not call other drug stores for prescription copies. We do not always have every medication and clients need to have a viable prescription at a drug store when we do not have a medication.

In Ashe County alone, three major manufacturing companies closed within a year of each other, leaving many people without jobs or insurance. In these mountain counties where there is little manufacturing to begin with, such closings are devastating. In addition, most jobs are in the service industries which are low paying jobs that rarely have prescription benefits.

Our clients give us profuse and positive feedback. It's not hard to please someone who was literally choosing between food and medication. Do you know some of the ways your patients may be trying to "stretch out" their prescriptions? They may take it every other day, or two out of three days; take half of the dose; substitute an herbal or over the counter medication; or take it only when they have symptoms, such as taking their blood pressure medication only when they have a headache.

We had a social work student from Appalachain State University who was doing an internship with us. She interviewed some of our clients as a part of her project. One lady tearfully told her how she could now afford to buy meat at the grocery store. Before, she said she would walk down the meat counter and just look, knowing she could not afford to buy anything. We were filling a medication for her that was costing her over $100 a month. A hundred dollars a month is a fortune to someone who is living on $700 a month.

Many of our new clients have recently lost their jobs or had a disabling accident or illness. They are so obviously distraught with how they are going to survive, e.g., pay their bills, utilities, house payment, groceries, gas, medical expenses. Is it any wonder they have prescriptions for antidepressants? Then there is the senior client whose daughter came by to see if her parents would qualify. They own their own house; they've worked all their life. But their $1200 a month income, which has been enough for them to just get by on, is not enough to pay for the new medications their doctor has just prescribed for diabetes. By the way, do we have those test strips for the glucometer?

Volunteer Jean Williamson and Martha Lyon, RPh, work in a recreational vehicle that has been converted into a mobile pharmacy.

Are all pharmacists familiar with North Carolina's Senior Care program? Basically, this is a program for seniors with limited income and no prescription insurance who have diabetes, heart disease or lung disease. North Carolina will pay for 60% of the cost of medications for one of these diagnoses, up to $600 per year. The program also links the senior up with someone who will help them get as many of their medications as possible from the manufacturer at no charge. There is more to the program than this, but the point is that it is another source of medication assistance.

Through this program, the Hunger Coalition was able to hire two full-time people to help clients get medications from the manufacturer's Patient Assistance Programs. This has been one of the most significant additions to our program. Physicians and their staff are not likely to complete all the paperwork required to get a patient into one of these programs. Our staff does all the paperwork and I fill the prescriptions when the medication arrives. This is better than having the medication arrive at the physician's office and be given to the patient unlabeled.

Then there are the various manufacturers "discount cards" e.g., the Pfizer Share Card, the Lilly Answers Card, the Novartis Care Card, the Orange Card, and the Together Rx Card. Would one of these cards be enough help for the client? They are much easier to apply for because the physician is not involved. One might think this area of expertise is as complicated and multi-layered as Infectious Diseases or Medical Devices.

We do not charge clients for our services or for their prescriptions. We do not have all medications all the time. We tell clients to please save a few dollars when we can fill their prescription in case we can't fill it next month. We have a donation can in the pharmacy and some clients routinely put something in the can. It reminds you that not everyone is looking to get something for nothing.

There are some legal issues related to the use of physician samples by a pharmacy. The FDA has rules regarding

(continued on page 10)

the keeping of records for samples received and dispensed. There is considerable extra paperwork that must be done. Fortunately, we have many volunteers who help with this job. Our pharmacy permit does not include controlled substances. There is a statement on the outside of the RV that indicates we do not carry any controlled substances. This makes robbery less likely, as well as reducing space and added paper work concerns.

Driving a pharmacy around has provided several interesting moments, like the day a construction truck came around the curve of a narrow road to Sparta and took my half of the middle, running me off the road. Fortunately, that sounds worse than it actually was. But the boulder on the side of the road did rip off the steps and blow out a rear tire. Then there was one of the early days when I accidentally left the lights on while I worked. Some nice men offered to jump start the battery, but it took a while to find where the battery was. Oh yes, then there was the day that one of the stabilizing jacks refused to retract. We were in the Plumtree Presbyterian Church parking lot (Plumtree is between Spear and Cranberry- just up the road from Minneapolis). I am certainly no mechanic, but I sure know more than I knew before this job.

When I think of interesting moments, I hesitate to tell of an everyday happening that never fails to make me smile. I restock the mobile pharmacy from the supply of samples we keep in the stationary pharmacy at the Hunger Coalition. Before I go out, I walk through the Boone pharmacy to pull needed stock. I often notice a new drug, or one I had never stocked before on the van. Something nudges me to take some to the van and it never fails that I get a new prescription for it that day, or I find that I have just the right amount to fill a prescription.

Weather, whether high winds or snow, is my biggest headache. We are currently working on a bad weather plan so that clients can get their medications when the van can not make a scheduled run. This is an example of one of the things I enjoy about my job. We constantly evaluate how we can be better at what we do. I get to put all that I learned of Total Quality Management and Continuous Quality Improvement to good use. We are constantly tweaking the processes and reevaluating the outcomes.

Some pharmacists may think programs such as Country Roads is taking business away from the retail pharmacy. I hope that we are eliminating some of the pharmacy's bad debt. But more importantly, I hope that we are making a difference, bringing a little goodness and hope, to folks who are struggling in ways most of us will never understand. Any pharmacist can do the same thing by knowing your patients well enough to pick up on the signs that they are having trouble paying for their medications. With kindness and tact, you can tell them about free pharmacies in your area and how to access patient assistance programs; you can have brochures in your pharmacy about the various manufacturers' program cards and the NC Senior Care Program. Maybe it's not too much of a stretch to think of this as an important component of "pharmaceutical care." ❖

Martha Lyon of Country Roads Pharmacy reflects at the end of a long day on the road.

About the Author...

Martha Lyon, RPh, is the Pharmacist Manager of Country Roads Pharmacy, operated by the Hunger Coalition in Boone, NC. She also works part-time for Watauga Medical Center. She was the recipient of the Elan Pharmaceuticals Innovative Pharmacist of the Year Award presented at NCAP's 2003 Annual Fall Convention. She can be reached at mwlyon@yahoo.com.

For more information about patient assistance programs and discount cards visit the following Web sites:

- **www.ncfreeclinics.org**
  North Carolina Association of Free Clinics.
- **www.needymeds.com**
  This site contains a good synopsis of the programs, toll free phone numbers, program eligibility requirements, etc.
- **www.rxassist.org**
  Volunteers in Healthcare Web site.
- **www.helpingpatients.org and medicare.gov**
  Provides a list of medication assistance programs and eligibility criteria.
- **www.benefitscheckuprx.com**
  Seniors can check personalized eligibility online for prescription and health care assistance.
- **rxhope.com**
  Only site with paperless online applications for select medications. Provides detailed information about each assistance program, searchable by drug or manufacturer.

Executive Committee Meets With Deans to Strengthen Relationships

Members of NCAP's Executive Committee met recently with the deans from North Carolina's three pharmacy schools. The group met at the Institute of Pharmacy to explore better ways to involve students in the Association and discuss what NCAP can do to help the pharmacy schools. NCAP Board members and the Executive Committee will meet this year with faculty and student leaders on each campus to further examine ideas for improving relationships.

Pictured left to right: 2003 NCAP President Jack Watts, Dean Robert Blouin of UNC-CH School of Pharmacy, Dean Ronald Maddox of Campbell University School of Pharmacy, NCAP Executive Director Fred Eckel, Dean Robert Supernaw of Wingate University School of Pharmacy, NCAP President Mark Gregory, and NCAP Board of Directors members Benny Ridout and Davie Waggett.

Lowry Drug Meets Patients' Special Needs

by Fred Lowry, Jr.

Briefly describe your overall practice.

Lowry Drug Co (LDC) was started by Fred Lowry, Sr., RPh, in 1959. Fred Lowry, Jr., RPh, joined him in 1980. In 1982 LDC began offering oxygen as an extension of its medical equipment services. LDC is a retail pharmacy with an extensive home medical equipment service that includes two Respiratory Therapists and one RN with 32 employees. In 1988, LDC opened Lowry Homecare Services that provides home infusion, including TPN, antibiotics, pain management, and fluid replacement. At that time, home infusion was in its infancy and required specialized home infusion nurses. The infusion service is currently limited to providing pharmacy only. LDC/LHS was accredited by the Joint Commission for Healthcare Organizations for services provided in 1990. The home medical equipment services are currently accredited by the Accreditation Commission for Healthcare. LDC joined Professional Compounding Centers of America (PCCA) in 1995 to further develop prescription compounding services. This led to formal pharmacy-based consultations with emphasis in natural health modalities.

What unique services do you provide?

LDC offers fee-based wellness consultations that cover current prescription medications, diet, exercise, and supplements. Recommendations are made in basic foundation areas and may include changes in diet, vitamins/minerals, herbal supplements, and homeopathics. The client process is goal oriented with emphasis on an individual approach. The client is usually willing to make change in their lifestyle. We also provide numerous hormone replacement consultations. Hormone saliva testing is used as a tool, and recommendations are made in writing to the client's physician. There are a number of physicians (including an endocrinologist) who make referrals to our pharmacist consultants for hormone related problems.

LDC offers wellness seminars for basic health practices. We offer a fee-based Foundations of Health series to provide such education. We also offer educational seminars on hormone replacement and men's health. Seminars are done on site in our conference room, in hospitals, and are sometimes done with physician involvement.

What kind of feedback do you get from patients and physicians?

Feedback from clients is positive. Some physicians were initially resistant to a pharmacist making recommendation on hormone replacement but now have become more open. There are a number of physicians who make referrals to LDC. There will, of course, always be some who are closed to the idea.

How did you determine the need for these services? How did you develop your practice to meet these needs?

The services that have developed have simply been because of recognizing needs that were not being met. Hormone replacement therapy is an excellent example of this need. Long before the HERS study came out, it was evident that there were many problems with HRT in its present practice. Many pharmacists who provided compounding pursued education related to their practice. This education process alerted them to such problems, so the HERS study was no surprise to compounders.

Fred Lowry Sr. and Fred Lowry Jr. provide a variety of services to their patients at Lowry Drug in Statesville, NC.

Are you being reimbursed for the services you provide?

Clients are willing to pay out of pocket for consultative services. With individuals being more educated and more proactive with their health, they are looking for answers. These clients, because of their motivation and our direction, are able to achieve excellent outcomes.

What advice would you give to someone who is interested in starting a compounding practice?

Since hormone replacement is a huge part of any consultation business, you MUST use proper precautions. Starting a com-

pounding business is an expensive proposition and most are undercapitalized. You must have adequate containment hoods and personal protection for dealing with hormones. Hormone dust in the air is absorbed on the skin and can quickly accumulate in fat tissue. This aspect should not be taken lightly.

Are there legal issues you deal with in this part of your practice?

There are currently none. There may be some confusion about pharmacists in a consultative practice, however, we are clearly practicing within our scope of practice. Pharmacists have always assessed the needs of an individual and made recommendations based on our training and expertise. The consultation is just a more formal extension of that practice. Being able to set aside time from a busy prescription practice allows us to understand the clients' needs and overall situation which makes us better able to be of service.

Where are you heading now with your practice?

We want to further develop our consultation practice to improve our follow-up and perhaps offer more related services. We will continue to pursue information and education in natural health modalities. I attend numerous education seminars each year and find the pursuit of such education stimulating and interesting. There is a whole world of educational opportunites, and such will be a lifetime pursuit. ❖

About the Author...

Fred Lowry, Jr. is owner of Lowry Drug Company in Statesville, NC. He can be reached via e-mail at fred@lowrydrug.com

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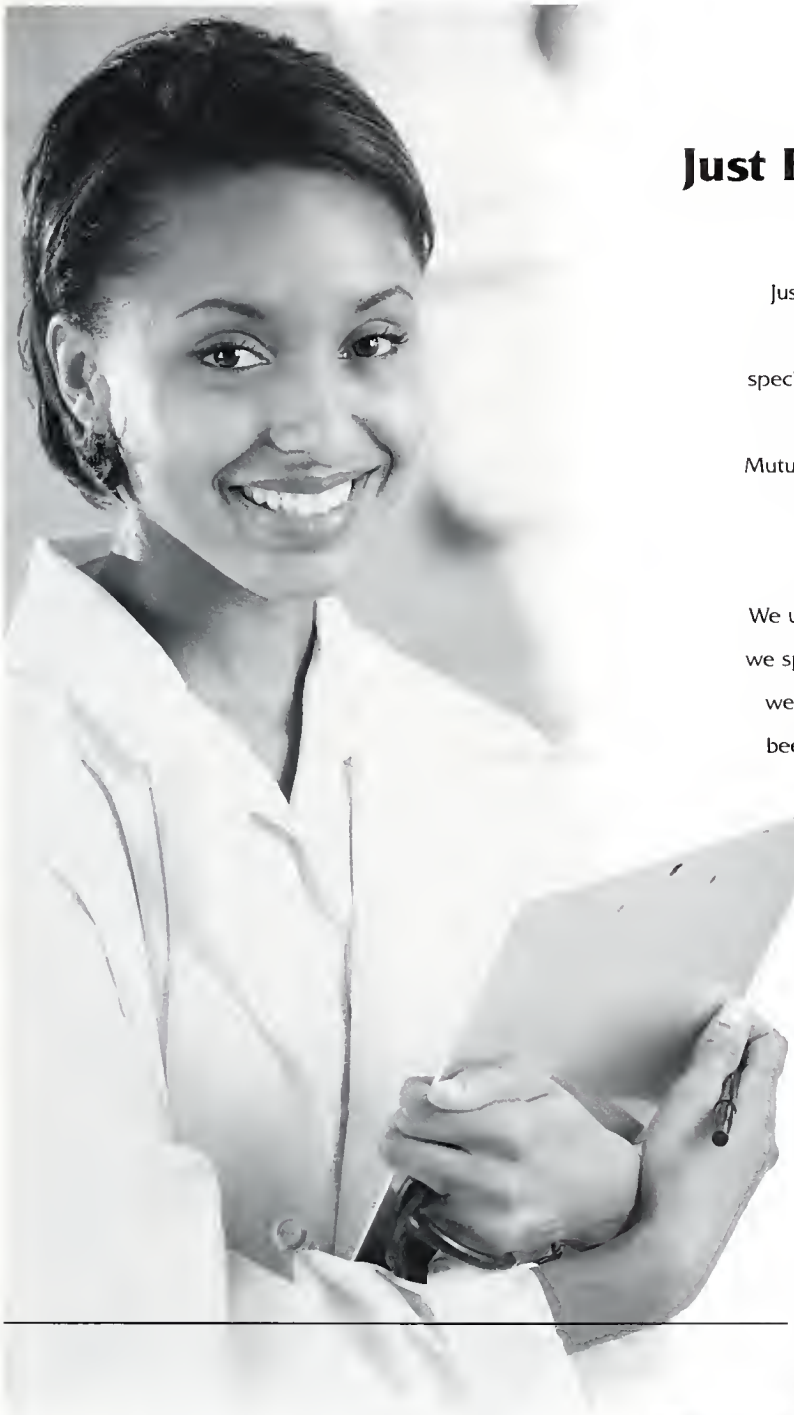
Pfizer Mobile Unit Available to Respond to Disasters

The Pfizer Mobile Response Unit was deployed to North Carolina last fall to assist with free medical care and prescriptions for persons affected by Hurricane Isabel. The van is available to respond to disasters in Georgia, South Carolina, North Carolina and Tennessee. While in North Carolina, the unit was staffed by a volunteer medical doctor with the NC Society of Family Physicians and with pharmacists provided by NCAP.

Pictured left to right: NCBOP member Bob Crocker, NC Strategic National Stockpile Manager Margaret Haas who works for the Division of Public Health Office of Preparedness and Response, NCBOP member Tim Rogers, Pfizer Government Relations Manager Myron Terry, NC BOP member Wallace Nelson, NCBOP member Stan Haywood and manager of the Pfizer Mobile Response Unit from Georgia, Charlie Grant.



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Medication Errors: How are we doing?

by William L. Harris

By the end of 2004, the question will be asked, "Are patients safer today than they were in 1999 when the Institute of Medicine published the report, *To Err is Human: Building a Safer Health System?*" In the report, a challenge was issued to reduce medication errors by 50 percent over five years. As health care providers, we need to assess the changes that have been implemented since 1999, measure the effects on patient safety and determine if we will meet this goal.

Surveys conducted in 2002 revealed that our patient's top concerns about medications were (1) having negative drug-drug interactions, (2) receiving the wrong medication and (3) experiencing harmful medication adverse effects. In one survey, 16% of Americans reported that they or a family member had experienced a prescription drug error involving wrong medication or wrong dose.

The pharmacy profession has been a leader in promoting the safe use of medications and we must respond empathetically that pharmacists are a major part of the solution to reduce the number, severity and mortality associated with medication errors. Adding a pharmacist to the rounding team reduces the incidence of preventable adverse drug events (ADE) by up to 78%, according to the literature. Many care providers are seeking the use of technology to solve medication errors, but pharmacists may be more effective.

LaPointe reported that a clinical pharmacist intercepted 4,768 medication errors over a five year period while rounding on a cardiology service. The most common errors were wrong drug (36%), wrong dose (35.3%), missing dose (10.2%), drug interaction (7.6%) and wrong dosage form (5.8%). Causes included lack of drug knowledge, prescribing errors in admission orders for home medications, and prescribing errors at patient discharge.

Kucukarslan reported that placing a pharmacist on rounds in general medicine reduced preventable ADE's by 78%. The intervention types included dose or frequency error (35%), adding a drug to the treatment regimen (21%), prescribing errors at patient discharge (8 percent) and inadequate lab monitoring (6%).

Leape reported that pharmacist participation on physician rounds in the ICU reduced preventable ADEs by 72%. Forty-five percent of the pharmacist interventions involved correction of dose, frequency, incomplete orders, wrong drug choice, and duplicate therapy. Other system issues included lack of drug information (25%), drug therapy change (12%), and drug interaction (4%).

These articles illustrate the types of medication use problems and system issues that pharmacists identify as part of their role on the rounding team. These interventions may not be reported in ADE data and need to be reviewed in addition to ADE's for a broader view of patient safety issues, potential ADE's, staff development opportunities, and quality improvement activities. Understanding the types of medication errors that occur and identifying the underlying system failures are fundamental to taking the right corrective actions that will reduce ADE's.

In addition to your own ADE data, literature articles also provide direction in the types of errors that occur and system issues that need resolution. Leape reported that wrong dose was the most numerous medication error (28%), followed by wrong drug choice (9%), wrong drug (9%), known allergy to drug prescribed (8%), missed dose (7%) and wrong dose time (7%). Seventy percent of their prescribing errors were intercepted by nurses and pharmacists, while only 6% of administration errors were intercepted due to limitations of patient safety systems in use. Wrong drug choice and wrong dose were most likely to cause patient injury. System failures included drug knowledge deficit (29%), dose and identity checking (12%), lack of patient information (11%), order transcription (9%), and allergy defense (7%).

Kanjanarat summarized the results of four ADE studies which also found that wrong or inappropriate dose prescribed was the most common medication error (22.4%), then wrong drug choice prescribed (17%), wrong drug administered (16.5%), inadequate patient monitoring (12%), wrong administration time (8.9%), and known allergy to drug prescribed (6.9%). System failures included lack of drug knowledge, lack of patient information, drug-drug interactions, lack of lab monitoring and allergy defense.

Phillips reviewed the types of medication errors associated with patient mortalities, which included wrong dose (40.9%), wrong drug (16.2%), wrong route (9.7%), wrong strength or concentration (5.7%), and wrong rate (5.6%). System failures included drug administration (29.8%), drug knowledge deficit (14.2%), dose and identity checking (13%), lack of drug information and drug name confusion (8.9%), transcription error (7.4%), communication breakdown (6.7%), drug preparation and dispensing errors (5.8%), manufacturer's poor labeling (5.6%), and infusion device problems (2.7%).

There are several common system issues which were identified by the articles for pharmacist intervention data and the preventable ADE data. These include (1) drug knowledge deficit (wrong dose, wrong drug choice, wrong drug), (2) lack of patient information at the point of care (allergy history, weight, lab information, home medications and doses), (3) drug administration errors (wrong drug, wrong route, wrong rate), (4) prescribing issues (poor handwriting, decimals, unclear orders, reliance on memory), (5) order transcription errors (misinterpretation, writing errors, drug name confusion) and (6) communication problems (failure to communicate, verbal orders, misunderstand, intimidation).

New technologies can help with these problems but may not always be affordable. You must review your own ADE data for weaknesses in your medication use system and focus on the areas that are the most concerning for patient safety. One approach is to identify practices that place patients at the greatest risk for injury if failure occurs (complex regimen, harm likely if incorrect) and processes in which there is no second check in place (high risk, low detection). Determine the best practice to reduce or eliminate the cause before the system fails again. Simulate tests of your medication use system to see if reported ADE's and system failures could defeat your safety systems.

In an ideal world, we wish for bar codes on all medications, computerized physician order entry (CPOE) with clinical decision support, robotic systems for dispensing medications, bedside computers with bar code readers and linkage to electronic MAR for point of care checks, and electronic surveillance systems to detect and alert us in real time for adverse patient effects, deviant lab values and treatment parameters outside the desired range. Until we can afford all these, we should continue to identify systems that fail and implement effective actions to prevent another failure. We should also recommend that pharmacists be utilized to participate on rounding teams, lead medication safety teams, review MAR's and patient profiles for inappropriate drug usage, and monitor patient outcomes for effective drug therapies and adverse patient effects.

Medication errors:

The following are examples of the type of errors that have been reported in the literature as ADE's. Review these scenarios to determine if your computer, medication use system and patent safety checks will prevent these types of events from becoming an ADE in your health system.

1. Morphine oral solution 20ml PO q4hprn was prescribed. Morphine 400mg dose PO was given (20 ml of 20mg/ml solution instead of 2mg/ml; both products stocked in automated dispensing machine).
2. Digoxin oral solution 75 mcg PO q8h x 3 doses started before surgery, then rewritten on post-op orders as q8h. (q8h doses were given for two more days).
3. Abilify 15mg PO daily was ordered as home medication but 50mg PO daily was prescribed and given in hospital.
4. Phenylephrine 50 mcg/min was the intended dose but 50 mcg/kg/min was administered via infusion pump for more than 24 hours.
5. Tylenol 10mg/kg for 3.6 kg patient was written as 360 mg PO q6h and one dose was given (36 mg was the intended dose; product stocked in automated dispensing machine).
6. Normal Saline was written for 3.7 kg patient as 10 ml/kg = 370 ml over 4 hours and administered to neonate (37 ml was the intended total volume; NS stocked in automated dispensing machine).
7. Heparin 100 units/kg/24hrs was ordered x 5 days but 100 ml/hr infused via AIM pump. (Heparin 50,000 units was prepared in 100ml for home care; intended rate = 0.8 ml/hr)
8. Alprazolam 0.5 mg PO was intended but 5 mg was ordered and given (no leading zero before the decimal).
9. Carboplatin 540mg IV was ordered but cisplatin 540mg IV was prepared and administered.
10. Levothyroxine 0.25mg PO was ordered and given instead of 0.025mg intended (calculation error during prescribing).
11. Acetylcysteine 1.4 Gm was ordered for Tylenol overdose, but 14 Gm was the intended dose (calculation error during prescribing).
12. Ceftriaxone 100mg IV q12hrs was ordered for 20 kg patient but 1 Gm q12h IV was intended for meningitis.
13. Magnesium sulfate 51 Gm IV infusion was prepared from floor stock by nurse and administered due to physician changing the original dose of 2 Gm by strike through and writing 1 Gm above it (nurse interpreted the dose as 51 Gm).
14. Vincristine 2mg was given intrathecally instead of IV due to mix-up of cytarabine and vincristine preparations at patient's bedside (Vincristine should not be prepared in a form that can be mistakenly given IT).
15. 7.4 ml of aminophylline IV solution (250mg/10ml) was given IV to neonate instead of 7.4mg (0.3 ml) due to confusion of cc and mg.
16. Order written for Oncovin 3.7mg/M2 = 5.55mg IV first dose, then 5.5mg/M2 = 8.25mg IV second dose and 7.4mg/M2 = 11.1 mg third dose (patient = 1.5 M2).
17. Prescriptions for Colchicine 0.6mg PO, one tablet daily and lorazepam 1mg PO, one tablet three times a day, were refilled and the pharmacy technician reversed the

(continued on page 18)

products in the prescription containers. 54-yr old woman took medication as labeled until harmed. ❖

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Thoughts, Beliefs, and Psychosocial Functioning in Chronic Pain Patients

Clinical Corner

Pain-related cognitions and beliefs have proven useful in predicting adjustment to chronic pain and the resulting level of psychosocial functioning. While adaptive thoughts and beliefs help patients cope with the experience of pain, negative ruminations and projections may actually exacerbate pain and emotional distress. In fact, negative cognitions have been "repeatedly associated" with pain, disability, and distress among chronic pain sufferers as well as with use of more pain medications and greater use of health care resources. The toll on patients and on the health care system might be reduced if more effective treatment interventions — specifically targeting negative thought and belief patterns — can be developed. A recent study examined how pain-specific cognitions and beliefs* are related to psychosocial functioning.

Pain cognition and pain beliefs were assessed and correlated in 163 patients with chronic pain. Pain cognition was measured using the Inventory of Negative Thoughts in Response to Pain (INTRP), a 21-item inventory composed of three scales: (1) self blame, (2) negative self-statements, and (3) negative social cognitions. INTRP scores are related to outcome measures including pain severity, psychological distress, and catastrophic thinking. Beliefs were measured with the Pain Beliefs and Perceptions Inventory (PBPI), a 16-item scale that measures the extent of agreement or disagreement with beliefs about pain along four dimensions; the belief that pain is (1) constant, (2) permanent, (3) worthy of self-blame, and (4) confusing and mysterious.

After controlling for demographics, employment status, pain severity, and pain beliefs, negative cognitions — especially negative self-statements (i.e, 'I am useless,' 'I am going to become an invalid,' 'I can no longer do anything') — were consistently related to poor adjustment to chronic pain. Such statements were positively associated with affective distress and interference of pain in daily activities and negatively associated ($p < 0.001$) with total activity level. (Conversely, patients scoring higher on self-blame reported higher levels of activity.)

Overall, the investigators determined that negative thinking was more predictive of patient functioning than pain beliefs. The findings provide an "explicit rationale for targeting the reduction of maladaptive cognitions" in the treatment of chronic pain. They concluded that the data support a biopsychosocial model for adjustment to chronic pain.

*Cognitions have been defined as "self-statements that are 'specific responses to an environmental event.'" Beliefs are "preexisting notions about the nature of reality that shape our perceptions of ourselves and our environment."
Source: Stroud MW, Thorn BE, Jensen MP, et al. Pain. 2000;84:347-352.

Call for Nominations: NCAP Election and Awards

NCAP ELECTIONS

Deadline for nominations, May 10, 2004.

NCAP will elect a 2005 President-Elect (to serve as President in 2006, 3-year term) and two At-large Board members (3-year terms). Members may submit nominations or requests to be considered for these positions. Send to NCAP Nominations Committee, 109 Church Street, Chapel Hill, NC 27516 (FAX 919-968-9430 or email to linda@ncpharmacists.org)

Acute Care Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term), three Executive Committee members (3-year terms) and one Delegate to ASHP (3-year term). Members of the Practice Forum may submit their nominations to Stephen Eckel, Chair of the Acute Care Practice Forum. FAX 919-966-7163 or e-mail to seckel@unch.unc.edu.

Ambulatory Care Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term) and one Executive Committee member (1-year term). Members of the Practice Forum may submit their nominations to Brenden O'Hara, Chair of the Ambulatory Care Practice Forum. FAX 919-467-3831 or e-mail to bpohara@eckerd.com.

Technician Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term) and 2005 Chair (2-year term). Members of the Practice Forum may submit their nominations to Michelle Valentine, Chair of the Technician Practice Forum. E-mail to MAVCPHT@aol.com or FAX/e-mail to NCAP at 919-968-9430 / linda@ncpharmacists.org.

AWARD NOMINATIONS

Deadline for nominations, May 10, 2004.

It is a privilege for the North Carolina Association of Pharmacists to recognize excellence within the profession. NCAP will hold its Awards Ceremony during the Convention October 25-27 in Research Triangle Park, NC. The Board of Directors invites NCAP members to make nominations for the following awards. Nominations must include biographical data on the nominee for review by the Awards Committee. Submit to Awards Committee, NCAP, 109 Church Street, Chapel Hill, NC 27516, Telephone 800-852-7343; FAX 919-968-9430 or e-mail linda@ncpharmacists.org.

Don Blanton Award: Presented to the pharmacist who has contributed most to the advancement of pharmacy in North Carolina during the past year. This award was established by Charles Blanton in memory of his father, Don Blanton, who served the North Carolina Pharmaceutical Association as President in 1957-58.

Elan Pharmaceuticals Innovative Pharmacy Practice Award: Presented to a pharmacist practicing in North Carolina who has demonstrated Innovative Pharmacy Practice resulting in improved patient care.

Pharmacists Mutual Distinguished Young Pharmacist Award: Criteria for this award are: (1) Entry degree in pharmacy received less than 10 years ago (1994 or later graduation date); (2) Licensed to practice pharmacy in NC; (3) Actively practices retail, institutional, managed care or consulting pharmacy; (4) Participates in national pharmacy associations, professional programs, state association activities and/or community service.

Wyeth Pharmaceuticals Bowl of Hygeia Award: Criteria for this award are: (1) Licensed to practice pharmacy in NC; (2) Has not previously received the Award; (3) Is not currently serving nor has he/she served within the immediate past two years on its awards committee or as an officer of the Association in other than an ex officio capacity; (4) Has compiled an outstanding record of community service, which, apart from his/her specific identification as a pharmacist, reflects well on the profession.

Pharmacist/Technician of the Year: Each Practice Forum will honor a Pharmacist/Technician of the Year. Criteria are: (1) Service to the profession, (2) Contributions to pharmacy programs; (3) Cooperation with the entire health care team and (4) Service to the community. Members of the Practice Forum may submit nominations for these awards. Nominations must include biographical data on the nominee.

Acute Care: Submit nominations to Anna Garrett, Chair, Acute Care Nominations Committee. E-mail anna.garrett@cornerstonehealthcare.com.

Ambulatory Care: Submit nominations to Brenden O'Hara, Chair, Ambulatory Care Practice Forum. FAX to 919-467-3831 or e-mail to bpohara@eckerd.com.

Chronic Care: Submit nominations to Cecil Davis, Chair, Chronic Care Practice Forum. FAX to 800-771-8942 or e-mail cecildavis@brookcare.com.

Technician: Submit nominations to Michelle Valentine, Chair, Technician Practice Forum. E-mail to MAVCPHT@aol.com FAX / e-mail to NCAP at 919-968-9430 / linda@ncpharmacists.org.

CONTINUING EXCELLENCE PROGRAM

Deadline for applications, August 2, 2004.

The Continuing Excellence Program recognizes individuals who have distinguished themselves through sustained service to the profession and the public and promotes an awareness of NCAP and the profession of Pharmacy among the public and other health professions. Program Criteria and application form are available on the NCAP Web site at www.ncpharmacists.org or you may contact Linda Goswick at NCAP 800-852-7343, FAX 919-968-9430, e-mail linda@ncpharmacists.org. Award recipients will be recognized at the October Convention in Research Triangle Park.

NCAP Election Results

The NCAP fall election results are as follows. Members began serving their terms January 1, 2004.

President-Elect:
Davie Waggett
NCAP Board of Directors:
Kathey Fulton
Dan Hardy
Acute Care Chair Elect:
Debbie Miller
Acute Care Executive Committee:
Alyce Holmes
Steve Novak
Jane Younts
ASHP Delegates:
Steve Novak
Dennis Williams
Ambulatory Care Chair-Elect:
Leigh Foushee
Ambulatory Care Executive Committee:
Gretchen Jenkins

UNC Students Win ASHP Clinical Skills Competition Two Years in a Row

Developing patient care skills, preparing for residencies, and enhancing career development skills were just a few of the topics covered during the specialized programming for pharmacy students at the American Society of Health-System Pharmacists' (ASHP's) 38th Midyear Clinical Meeting, December 7-11, 2003 in New Orleans. Activities for the more than 2,750 students who attended included the announcement of Stephanie Burge Hollowell and Sarah Ford of the University of North Carolina at Chapel Hill as winners of the Society's eighth National Clinical Skills Competition. This is the second year in a row that UNC has won this competition.

Seventy-five teams who won preliminary competitions at their local pharmacy schools participated in the activity. The competition, which was sponsored by Pfizer U.S. Pharmaceuticals Group, offered students the opportunity to analyze actual patient cases, demonstrate their skills in assessing a patient's medical history, identify drug therapy problems and treatment goals, and recommend a pharmacist's care plan, that included monitoring variables and desired outcomes.

Other activities for pharmacy students included sessions on resume and curriculum vitae writing and financial management and panel discussions about residency training and careers in health-system pharmacy. Student leaders from pharmacy schools around the country also met during the Midyear to exchange ideas for student society activities. "We are pleased to be able to offer the Clinical Skills Competition and student programming to introduce the practitioners of the future to the skills they need to take on leadership roles in the profession," said ASHP President Daniel M. Ashby, M.S., FASHP.

NCBOP Director Receives Prestigious Pharmacy Award

David Work, Executive Director of the North Carolina Board of Pharmacy, will receive the 2004 Hubert H. Humphrey Award recognizing his legislative efforts on behalf of the American Pharmacists Association. He will receive the award in March at APhA's annual meeting in Seattle, WA. The award is named for the former U.S. vice president who was a pharmacist. It was established in 1978 to recognize APhA members who make major contributions in government and/or legislative service.

As a pharmacist and attorney, David has headed the state pharmacy board since 1976. He came to Chapel Hill after serving as director of association affairs for the National Association of Retail Druggists (now the National Community Pharmacists Association). He received his pharmacy degree from the University of Iowa and his law degree from the University of Denver.

"Reach One for NCAP" Winner Announced

Harold King of Medicap Pharmacy in Wilmington received a free 2004 NCAP membership for participating in the "Reach One for NCAP" campaign. The campaign is designed to help NCAP increase membership in order to better serve North Carolina pharmacy. Each NCAP member who recruits a new member into the Association has their name entered in a drawing for a free membership. The last drawing was held at NCAP's Annual Convention in October, 2003. If you'd like to help our Association grow please encourage a friend or co-worker who is not already an NCAP member to join. Call NCAP for more details.

2004 Calendar

March 23: ***NCAP Executive Committee Meeting,*** Wingate University.

March 25-26: ***2004 Carolina Regional Conference (Chronic Care Practice Forum Meeting)***, University Hilton, Charlotte.

April 17: ***Pharmacy Student Leaders Forum.*** Student leaders from the three schools of pharmacy will meet at the Institute of Pharmacy in Chapel Hill.

April 28-29: ***NCAP Acute Care Practice Forum Meeting (formerly NCAP Spring Meeting)*** Sheraton Four Seasons, Greensboro. Excellent speakers, CE and networking opportunities.

May 1: ***NCAP Council Meeting Day.*** NCAP Board, Council and Committee orientation followed by meetings at the Institute of Pharmacy in Chapel Hill.

June 16: ***Pharmacy Day in the Legislature.*** An opportunity for pharmacists to meet with their legislators and attend a reception in Raleigh at the North Carolina Museum of History.

July 16: ***NC Pharmacy Residents Conference,*** Friday Center, Chapel Hill.

September 10-12: ***Pharmacy Practice Seminar (Ambulatory Care Practice Forum Meeting)*** Wilmington Hilton, Wilmington, NC.

October 25-27: ***NCAP Annual Convention,*** Sheraton Imperial, Research Triangle Park, NC.

For more information about these upcoming events visit www.ncpharmacists.org or call NCAP at 919-967-2237.

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Visit www.aphameeting.org for more information.
For questions, contact apha2004@aphanet.org.

Members, watch for registration forms online in the Fall and in the November issue of *Pharmacy Today*.

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Pharmacy Network Foundation Offers A Second $50,000 Challenge Grant

Are you ready to accept another challenge? NCAP's building needs lots of repairs so we are asking you to help by making donations to the NCAP Endowment Fund. We raised $50,000 last year and received a matching grant from the Pharmacy Network Foundation. PNF is offering another $50,000 challenge grant for 2004 to help us achieve our ultimate goal of $200,000. Please say **"I can."** We need your tax-deductible contributions in order to preserve our building.

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North Carolina Pharmacist

Volume 84, Number 2 ...applying drug knowledge to improve health Spring, 2004

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North Carolina Pharmacist

Volume 84, Number 2 ...applying drug knowledge to improve health Spring, 2004

Inside

Don't forget about HIPAA Security!

"Covered entities" have more to do to be in compliance. It is time to work on the HIPAA Security Regulations! The deadline for compliance is April 21, 2005. HIPAA training should be an ongoing process for your pharmacy! In order to stay compliant with HIPAA, it is important that you ensure your employees are educated on HIPAA in its entirety...including Privacy and Security. Additional security policies and documentation are also required. You must keep your pharmacy up-to-date in order to be in compliance. For an affordable annual license (less than $700), HIPAAstepsRx will help you manage HIPAA, and deal with Security. It is the only tool you need! No more combing through manuals, CD-ROM, or attending expensive seminars. Get started now so that you have all of the materials that you need! **For more information, visit the NCAP Web site or call toll free 1-866-229-1763 and *TO RECEIVE A DISCOUNT, BE SURE TO TELL THEM YOU ARE AN NCAP MEMBER.***

Fred Eckel
Executive Director

Pharmacy and the Medicare Act of 2003

In 1965 the Medicare Program was introduced, and today it covers 41 million Americans. It serves all eligible beneficiaries without regard to income or medical history. It plays a central role in the US health care system.

Last year the first major addition to Medicare was passed with the enactment of the Medicare Prescription Drug, Improvement and Modernization Act. Although controversial, the new provisions could have a major impact on pharmacy practice. The major provisions of the law go into effect on January 1, 2006, with the availability of Part D, a prescription drug benefit, but the transition program begins this spring with the availability of a drug discount card and a transitional assistance program.

The early part of my pharmacy career in North Carolina as Director of the Plan of Pharmacy Assistance was facilitated greatly by the passage of the Medicare Act which made more financial resources available to hospitals. Therefore, it was much easier getting hospital administrators to agree to employ pharmacists. Will this newly passed law do the same thing for community pharmacy advancement?

Making payment available to pharmacists for Medication Therapy Management Services (MTMS) under the new Part D provision would seem to suggest this possibility.

Finally, there is now the endorsement within federal legislation, that cognitive services provided by pharmacists are valuable. Although this MTMS is not exclusively a pharmacist function, the pharmacist is the only professional given as an example of who can do this. If we can successfully demonstrate that the cost of these services will be offset by the savings that occur from reducing medication misuse, then these services should prevail because it will be a cost savings program even if the payment for the cost of prescription drugs is modified or repealed due to financial constraints in the federal budget.

> *"Finally, there is now the endorsement within federal legislation, that cognitive services provided by pharmacists are valuable."*

In this issue we focus on the transitional part of the bill, the Drug Card. Many pharmacists are concerned that the reported savings of 10% to 25% will come from the pharmacist's pocket or at best be shared with the manufacturer. Pharmacists with this perspective see this program as the possible demise of community pharmacy because pharmacies will not make enough money filling prescriptions to stay open. Thus, there will not be pharmacists available to provide MTMS. Only time will reveal who is right.

Until then, pharmacists can expect to be bombarded with questions from their customers asking what to do. By being knowledgeable we can really assist our patients and enhance our value. National pharmacy organizations will be doing their best to educate their members, and pharmacist employers will find themselves also trying to educate their employees. We will do our best at NCAP to keep you informed as well.

We hope this issue will help you develop the understanding you will need to assist your patients, and demonstrate another reason why NCAP membership is important.

The next few months will be very exciting, as patients are enrolled in this drug benefit. Will a future generation of pharmacists be able to look back to 2004 and see that the Medicare Part D benefit was the beginning of growth and improvement in pharmacy practice? I hope so. ❖

North Carolina Association of Pharmacists
109 Church Street
Chapel Hill, NC 27516
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Mark Gregory
President, NCAP

Medicare Rx Drug Discount Cards:

Questions for Thought

Dear NCAP Members,

Our NCAP Journal today focuses on one of the first of many major changes in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 impacting community pharmacy - the discount card. We are well into the last weeks of March (at press time), and there are certainly more questions than answers. One undisputable fact is that there will be plenty of pharmacy and patient confusion. Upon approval of discount card providers at the end of March, the marketplace will be loaded with information. Some marketing information may be clear and concise and some misleading. Some information will be backed by large groups and some by smaller groups. Some programs will be Medicare approved, and some will not. As we all prepare for this launch, we should each develop a list of questions and then seek appropriate answers. Let me suggest a few questions for thought:

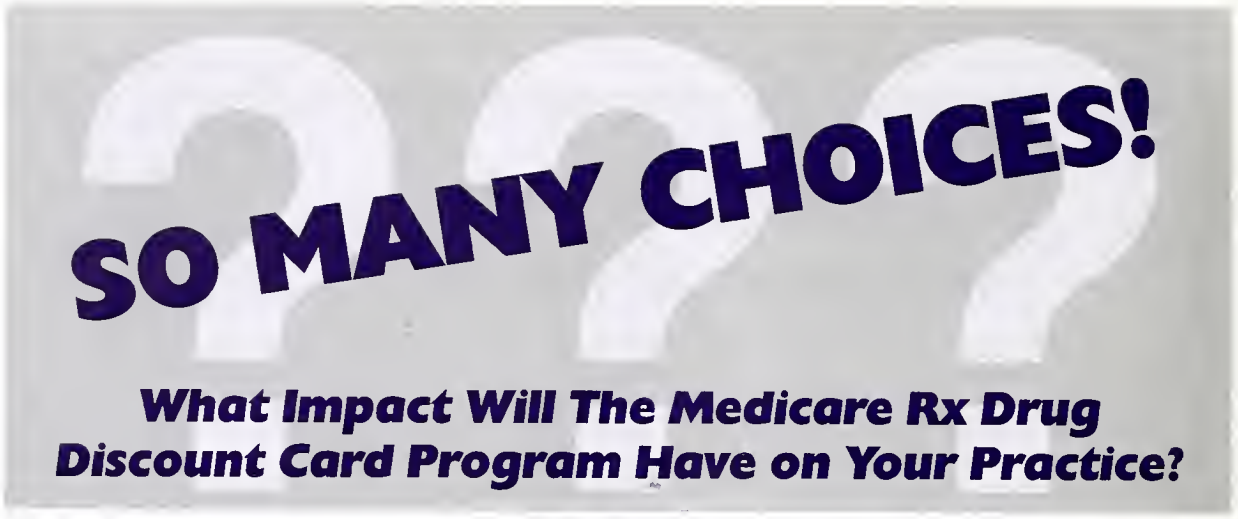
- How will Medicare senior recipients decide what is best?
- What individual or entity will help them decide what is best?
- How will Medicare seniors sort through the multitude of cards?
- What will be the criteria for deciding what is best?
- With discounts to the patient differing among discount card providers, extended to the drug (and dispense quantity) level due to different network rates, formularies and rebate negotiations how will the best program be measured?
- How is the 1-800-MEDICARE phone number going to handle millions of additional calls from pharmacists and patients?
- What is the feasibility of CMS being able to maintain a Web site database reflecting drug costs for all card sponsors, by pharmacy provider, for each individual drug?
- If eligible recipients choose the best discount card based on "saving money," what will be the consequences?
- How will choosing a card provider today affect reenrollment in late 2004 and then enrollment in the 2006 Medicare Part D program?

With all of these open-ended questions, we must keep in mind the value in having open access to the community pharmacy. Our profession is one of service and relationship between a patient and pharmacist. The current dilemma of drug affordability jeopardizes that relationship. Answers to each question must include solutions to enhance the patient/pharmacist relationship and not compromise that critical interaction.

Good luck. Be an NCAP advocate, and stay tuned.

Sincerely,
Mark Gregory, RPh
President, NCAP

...applying drug knowledge to improve health



What Impact Will The Medicare Rx Drug Discount Card Program Have on Your Practice?

The implementation of the Medicare Prescription Drug Improvement and Modernization Act of 2003 is underway and more than 100 companies will offer prescription drug discount cards for uninsured seniors. We've asked pharmacy professionals in North Carolina, as well as representatives from our state government, to comment on the changes taking place in pharmacy as a result of this new program.

Background

By Galen Jordre, RPh, Executive Vice President
North Dakota Pharmaceutical Association

January 31 was the deadline for potential sponsor applications for the Medicare Prescription Drug Discount Card Program. In May the more than 100 CMS approved sponsors will start marketing to beneficiaries and enrollment will be open to Medicare beneficiaries (except for those who have Medicaid drug coverage). Approved discount card sponsors will be required to provide program information, such as enrollment fees and prescription drug prices, to eligible Medicare beneficiaries. Beginning in June, the discount cards will provide discounts off the regular cash price of prescription drugs. The expected savings for beneficiaries will be 10 to 15 percent on total drug spending, with discounts of up to 25 percent or more on individual prescription drugs.

In addition, Medicare will provide $600 in 2004 and up to an additional $600 in 2005 to Medicare beneficiaries whose incomes are not more than 135 percent of poverty ($12,123 for single individuals or $16,362 for married) if they do not have other drug coverage. These funds will be provided through the Medicare-approved drug discount card in which the beneficiary enrolls. When applying the $600 toward prescription drug purchases, beneficiaries at or below 100 percent of poverty will pay 5 percent coinsurance and beneficiaries above 100 percent of poverty will pay a 10 percent coinsurance.

Medicare beneficiaries will have at least two choices of approved cards in each state. At least 30 days prior to the opening of enrollment, CMS will provide information about the approved discount card programs through www.medicare.gov and 1-800-MEDICARE. Other information sources will be used along with a price comparison Web site that will enable beneficiaries to compare negotiated prices, fees, and other card program features.

Medicare-approved discount card programs can charge an enrollment fee up to $30 per year. Medicare will pay the enrollment fee for beneficiaries who qualify for the $600. Persons must be enrolled under Medicare Part A or B to be eligible for the drug discount card program, if not receiving outpatient drug benefits through Medicaid, including 1115 waivers. Those eligible for the $600 transition allowance must not receive outpatient drug coverage from any other sources, including Medicaid. Generally, once qualified for the $600, a person is qualified until the new Medicare drug benefit begins.

Beneficiaries may enroll in only one discount card program. To enroll, the beneficiary will first select the discount card program that best meets his or her needs and then submit an enrollment form to the selected approved discount card program. Beneficiaries requesting the $600, must submit income and other information and attest to its truthfulness. CMS will verify this information and notify the approved discount card program of the beneficiary's eligibility and enrollment outcome. Eligible beneficiaries are enrolled and may start obtaining discounts and, if receiving the $600, using these funds to purchase prescription drugs as early as the first day of the following month.

An eligible beneficiary can enroll in an approved discount card program at any time. After the initial election, the beneficiary will have the option, for 2005, of choosing a different card program during the annual coordinated election period, between November 15 and December 31, 2004. In addition, a beneficiary may change cards under other specific circumstances.

A state is the smallest service area allowed. If the service area includes additional states, then the entire additional state must be included. Medicare-approved drug discount cards must provide access to retail pharmacies with the minimum requirement for rural areas that 70 percent of beneficiaries live within 15 miles of a participating pharmacy. While this may sound good, this

figure is based on averages for the entire country, not specific states or counties. Medicare-approved programs may offer a mail order option in addition to their contracted retail pharmacy network, but are prohibited from providing a mail-order only program, and they may not require enrollees to use mail-order pharmacies.

Nearly all prescription drugs that can be purchased at retail pharmacies are eligible for discounts and use of the $600. Supplies associated with the injection of insulin are also included. Discount card programs must obtain rebates from drug manufacturers and other discounts to lower costs of prescription drugs purchased by enrollees. Formularies may be used to obtain deeper discounts. However, even if a drug is not on the sponsor's formulary, the $600 can still be used to purchase the prescription drug. Programs with a formulary must offer a discount on the types of drugs commonly used by Medicare beneficiaries in more than 200 classes of drugs. Approved discount card programs, if they choose, may offer discounts on over-the-counter drugs. However, the $600 cannot be used to purchase these drugs.

Approved discount card sponsors must comply with the HIPAA privacy provisions protecting beneficiaries' health information. A beneficiary's protected health information (PHI) can only be used for the health care operations and marketing of products and services that come under the scope of the Medicare endorsement. The statute provides additional restrictions beyond the HIPAA privacy provisions that prevent a sponsor from seeking authorization from a beneficiary to use PHI for any activity outside the scope of the Medicare endorsement, including marketing.

Out of the 15.4 million beneficiaries who are eligible for the card it is estimated that 7.3 million will participate in 2004. Of these, 2.6 million will be eligible for the card only and 4.7 million will be eligible for the card and $600 assistance.

Community Pharmacy

By Gene Minton, RPh
CEO, Drugco Pharmacies
Chairman, ACP

The Medicare Prescription Drug program in a perfect world should be a way for seniors in the United States to afford the type of health care available to the most prosperous and forward thinking country in the world. Drugs that are available today have the ability to keep more people healthy and vital, out of the hospital, and making positive contributions to society. Unfortunately, often the very people who would most benefit from the miracle drugs of today just cannot afford the costs associated with them. It would be great if the program as written addressed this cost for the majority, but it does not. Most people will find that they fall in the group who really will see little benefit to them, as their premiums for coverage and their copayments will be minimally supplemented by the benefit itself.

So then, where does this leave us as pharmacy providers? Until the true program starts up in January, 2006, savings to the vast majority of our patients will be available as discount programs administered by various PBM's and PBA's. Pharmacies are being asked to provide the discounts and pay for the administrative costs associated with the programs. The drug manufacturers and the insurance companies are virtually immune to any cost saving scenarios that will result from these discount cards and their continued emphasis will be on either maintaining market share or increasing the number of covered lives. The true effect of these discount cards will be the movement of even more of our private pay patients to some type of a third-party program. If you look at the figures, you find that average prescription prices for third-party patients are markedly higher than those prices paid by private patients. The reason is quite obvious-when you pay private "out of your pocket" you tend to shop for the best price and the lowest cost therapeutic option available. When the true prescription benefit program starts in 2006, many more people will be moving to a third-party plan of some type which I believe if past history is any indicator, will result in higher average prescription prices as people will lose their ownership in the true cost of their medications. I forecast the overall result will be higher average prescription prices, lower margins for the drug stores, a program that costs billions more than estimated, and the US population wondering what in the world went wrong. Community pharmacies will suffer and I believe that patient access will also be adversely affected as locations begin to disappear. Taxpayers will also bear the burden for a program that will be more costly and less effective than stated.

Most pharmacies, including my own, will honor many of the new Medicare discount cards coming out. The Association of Community Pharmacists, in conjunction with NC Mutual Drug, has put together their own discount card program to help seniors control drug costs and will help the member stores have a program that allows them to have input in the process. Plans are for the association to have a preferred "approved" card that will be chosen from those that are being developed and market this card to their patients. All community pharmacists should become very familiar with the many facets of the Medicare Prescription Drug program so that they can serve their patients and make informed decisions about which programs and plans will allow them to stay in business. My hope is that by working with patients and understanding the situation, community pharmacists will be able to recommend programs to these patients that will continue to allow them to serve the patients.

By Harold B. King RPh, CDM
Medicap Pharmacy

The Medicare Discount Drug Program (MDDP) is the first part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 drafted by the Bush Administration and Congress to get lower drug costs to elderly patients and is set to start on June 1, 2004. The MDDP uses a discount card that gives to the recipient the lower of a negotiated rate or the pharmacy's usual and customary price,

(Continued on page 8)

whichever is lower. The discount is to be negotiated from both retailers and manufacturers and passed on to the beneficiary. This will affect a large number of people who have been traditionally strong users of prescription medications, and pharmacists/pharmacies who derive a huge economic benefit from serving this population. I foresee two things that will happen in the transaction. One is confusion as beneficiaries seek to see which card is best, their existing discount card or the new MDDP card. This will cause untold headaches for the elderly as well as the pharmacists when asked the question "Which is better?" It will be difficult to compare without using the online resources that the Act calls for. The other problem, for pharmacies, will be the conversion of cash customers to discount customers. By definition this will be a financial burden to pharmacists and their employers. I would caution readers to not oversimplify this transaction as the card gives the lower of usual and customary, or the negotiated rate. In urban areas where there is a lot of competition, as in my area, usual and customary prices are lower on many maintenance drugs than many discount plans, hence no savings. This discrepancy will cause discontent among the elderly and cause them to think at times that this Medicare benefit is really no benefit at all. The MDDP derives its benefits from the pockets of pharmacy owners/corporations and hence the pharmacist. One can only imagine the tightening of budgets for pharmacist/tech salaries as well as auxiliary help with this scenario. Manufacturers have been mentioned as sources of negotiated discounts but there is no apparent mechanism for it to reach the consumer. So the MDDP is at best a stopgap solution to the real problem of drug costs in the United States.

The next part of the Medicare Drug bill is set to start on January 1, 2006, and it has some interesting provisions of interest to community pharmacy. It expands drug importation to pharmacies and wholesalers and it is limited to approved Canadian sellers. It may enable pharmacies to reduce prices because of lower drug costs. The bill authorizes personal importation with safety protections and directs enforcement to focus on the cases that pose a significant risk to public health. Most significantly the bill provides "care management" for chronic conditions such as congestive heart failure, COPD, and diabetes. This includes self-care education for the beneficiary, primary caregivers, family members, and health care providers. The definition of self-care is vague and open to interpretation by all who read it. Pharmacists will be positioned by training and inclination to be providers of self-care education as they see it. I would encourage you to read the "Principles of Practice for Pharmaceutical Care" at http://www.aphanet.org/ at the Pharmaceutical Care tab. We will have an opportunity to make a difference in these patients' lives, reduce medication costs and improve care if we take the opportunity that will present itself in January of 2006.

The Medicare Drug Discount Card is a mixed bag for community pharmacy. There are some good things and some bad things about the Discount Card. The good is that there will be some people who will get their prescription filled who would not ordinarily do so. The bad is that the current cash payers will be converted to a reduced payment. This may be a wash. My attitude is that we will have to wait and see, but we must be proactive in choosing which plans we support and to steer patients to if asked by them.

We must communicate the following points to patients:

1. The discount cards are temporary until the Drug Benefits Program starts in 2006.

2. Once you enroll in a card program, it is difficult, if not impossible to change cards so be cautious and talk to your pharmacist before signing.

3. Pharmacies do not have to accept all cards so make sure to find out which ones your pharmacy is accepting.

4. Use your resources to find a card that's right for you.

Here are some questions we should have for plan sponsors:

- How does your plan differ from your competitors?
- Who would own the rights to the roster of patients and their eligibility?
- How is the plan design structured?
- Is mail order fulfillment offered? If so, is it mandatory and what is the rate? How does the mail order option differ from the retail option? Is there an incentive to the beneficiary to use mail order over retail?
- Solicitations require card sponsor to negotiate manufacturer rebate and/or concessions. How will you handle the redistribution of rebates and concessions? Will a portion cover the administrative fee, etc?
- What benefit does your plan design have for the beneficiary?

I am looking forward to "self-care" consulting and payment for these services that puts us more in control of our futures and will impact drug use in our nation for the better. That is the reason why I am a pharmacist, to help improve my patients' health through better use of medicines and more appropriate lifestyle changes. It is a thrill to make a difference in patients' lives. I hope to be remembered by my patients for that and I hope my colleagues will be ready for the challenge that is coming up. It is truly an exciting time to be a pharmacist in North Carolina!

Chain Community Pharmacy

By Mark Gregory, RPh
Vice President of Pharmacy & Government Relations, Kerr Drug

Each community pharmacy provider, whether they are a large chain, small chain, or independent, will have a different perspective or strategy with each element of Medicare changes. The discount card is one of many of the changes. We cannot ignore the other large changes coming at a future date such as changes with Medicare Part B drugs, DME impacts, effects on retiree benefit programs, revitalized Medicare Choice programs and the long-term effects of moving Medicare/Medicaid dual eligibles into the Medicare Part D program in 2006.

With that said, the Medicare Prescription Drug, Improvement

and Modernization Act of 2003, although highly political, is critically important because the number of Medicare eligible recipients will increase significantly due to aging population and the large role that prescription medications play in today's healthcare system.

As CMS has developed the discount card, it has been vitally important that the program was constructed to appreciate the dynamics of stakeholders in our industry. These stakeholders being pharmacy benefit managers, pharmacies, pharmaceutical manufacturers, and patients. Further understanding of these entities will continue to be critical in order to have a fair and balanced program to meet the objective of providing prescription drug affordability while not sacrificing access to community pharmacies.

As discount card provider contracts have been offered, some of the items that need to be understood include reimbursement rate (brand and generic), limitations on extended days supplies, how savings will be passed on to the patient, incentives for recipients to utilize mail, pharmacy network access, unique transaction requirements (i.e. enrollment fee, transitional assistance tracking, generic savings, preferred drug messaging) and how details of the enrollment and reenrollment process will take place. Each one of these important components should not be minimized.

A number of details of the discount card are still undetermined (see my opening remarks, page 5) so it is difficult to predict, even a week from now, what information will be forthcoming. As mentioned, current activity includes:

- Discount card providers are now developing through negotiation networks with pharmacy providers
- Discount card providers are negotiating programs with pharmaceutical manufacturers
- Discount card enrollment programs are being crafted
- CMS is under evaluation of the ultimate discount card providers
- Nationwide CMS multimedia campaigns have been launched
- State level senior training programs via various agencies
- Senior groups (AARP, etc.) are looking to position with a preferred card
- Medicare Choice programs are recruiting Medicare eligibles
- Non-Medicare endorsed discount cards are being introduced into the market

Meanwhile, with all of these items in progress, there is not a lot of detailed information I can share about actual implementation of the programs to store pharmacy associates. I expect that to come soon.

Operationally, at the store level, we can expect the worst. Although there will be guidance from discount card marketing initiatives, state agencies, and CMS, the Medicare senior will call upon their pharmacist for advice. Sorting through the multitude of options will be difficult. Educating pharmacy associates, having appropriate materials available at the point of contact, and directing Medicare recipients to information sources that will give the most comprehensive and accurate information will be of greatest value.

The offering of multiple discount card options at each

(Continued on page 10)

individual community pharmacy will vary. We do not know what the total offering will look like until providers have been approved by CMS. Most likely pharmacy providers will choose one or a small mix of preferred cards, but accept multiple cards based on the structure of each individual card program. Pharmacies positioning themselves with one or a handful of preferred discount cards will also most likely have programs to assist patient to enroll in those programs. Enrollment assistance will have opportunities to share in the enrollment fee associated with that program.

Certainly, the devil will be in the details as they are made available.

Stay tuned.

Potential Long-Term Care Impact of the Medicare Modernization Act

By Ross Brickley, RPh, MBA
President, ASCP

The Medicare Prescription Drug Improvement and Modernization Act of 2003 is the largest expansion in the health care program since Medicare was created in 1965. Although the program will greatly increase access to medications, there is currently nothing in the law that ensures that the medications will be used in a safe and effective way. As currently being drafted, regulations implementing the Medicare outpatient prescription drug benefit include a number of provisions that may threaten the health, safety, and quality of life of America's seniors. Narrowly drawn formularies may restrict seniors' access to medically necessary medications and dosage forms; utilization controls in the hands of pharmacy benefits companies could compromise the ability of health care providers to determine medical necessity, and create economic incentives that shift costs to other payers, increase overall plan costs, and increase health risks for Medicare beneficiaries; and ill-defined medication management provisions could result in inadequate services performed by unqualified individuals.

Most Seniors Don't Know Medicare Drug Bill Passed, Survey Says

A survey released Feb. 26 by the Kaiser Family Foundation shows seniors are confused about the outcome of the Medicare prescription drug debate and the prescription drug law. While about two-thirds of seniors report following the debate closely, just 15 percent say they understand the new prescription drug law very well and almost seven in 10 don't know that it passed and was signed into law. The January/February Kaiser Health Poll Report survey shows just how big a challenge it will be to educate seniors about the new Medicare prescription drug law. As of Feb. 8, only 15 percent of seniors (7 percent of the public overall) say they understand the law "very well"; 24 percent of seniors (26 percent of the public) say they understand it "somewhat well"; and 60 percent of seniors (64 percent of the public) say they understand it "not too well" or "not well at all." One poll finding was particularly striking: 27 percent of seniors think the law did not pass, and 41 percent say they did not know whether or not it passed. Some 32 percent of seniors correctly say the law was passed and signed. Awareness is even lower for the general public (23 percent say it was passed and signed).

Long-Term Care Medicare Recommendations to CMS:

Recommendation #1: The Medicare drug benefit must include a liberal physician formulary override process.

Recommendation #2: The list of therapeutic categories, for use in developing formularies for the prescription drug plans, should be substantially expanded from the 209 categories to be used in the discount card program.

Recommendation #3: The number of medications included on the formulary within each therapeutic category should vary according to the number of medications available within that category. A minimum of two medications should be included on the formulary for therapeutic categories with three to five medications. At least three medications should be included on the formulary when six or more medications are available within a therapeutic category.

Recommendation #4: CMS regulations should designate specific high-risk conditions for which drug formularies may only guide initial selection of therapy for new patients with these conditions. Prescription drug plans should not require that stable patients with these conditions be changed to a different medication for cost containment purposes.

Recommendation #5: Residents of nursing facilities need medications provided in special packaging (i.e. unit-dose), and other specialized pharmacy services, to ensure patient safety, promote efficiency in medication administration, and ensure integrity and accountability of controlled medications (e.g. morphine, oxycodone).

Recommendation #6: CMS should publish a list of "potentially inappropriate" medications that prescription drug plans would not be permitted to include on their formularies.

Recommendation #7: In approving the list of drugs proposed for formulary inclusion by the prescription drug plans, CMS should ensure that medications with a wide variety of dosage forms are included on the formularies. Otherwise, non-formulary medications will be needed whenever a liquid or other special dosage form is needed for a Medicare beneficiary.

Recommendation #8: Injectable dosage forms of medications, especially intravenous hydration and injectable antibiotics, must be specifically included in the formularies of prescription drug plans, or required by CMS through "emergency access" standards.

Recommendation #9: CMS regulations should specify that prescription drug plans will provide payment for all medically necessary medications for nursing facility residents.

Recommendation #10: CMS should refrain from releasing draft regulations for implementation of a Medicare drug benefit for nursing facility residents until completion of the long-term care study mandated by Congress. The study results should be used

to develop appropriate regulations, as intended by Congress.

Recommendation #11: When Medicare beneficiaries move into a nursing facility, medications and pharmacy services should be provided by long-term care pharmacies with the capability of providing the pharmacy services needed by the facility and the residents of the facility. The Medicare drug benefit design should address these needs, including payment for medically necessary medications and needed pharmacy services.

Recommendation #12: The Medicare drug benefit design should permit long-term care pharmacies to use specialized formularies developed for the frail elderly residents of long-term care facilities, rather than imposing a more general and limited drug formulary that might not meet the needs of this special population.

Recommendation #13: CMS regulations should establish guidelines for payment for special packaging and other pharmacy services needed by targeted beneficiaries under the MMA. These regulations should ensure that such needed services are made available to beneficiaries who need these services, based upon assessment of a physician who determines that these services are needed and refers the individual to receive these services. Prescription drug plans and managed care plans should not be permitted to deny these services to beneficiaries who need them to remain in their residence of choice.

Recommendation #14: The Medication Therapy Management Services provisions should be moved to Medicare Part B, rather than Part D, where it now resides. Although this would apparently require legislation to change, the economic incentives would be in better alignment with this move. MTM Services, such as disease management and medication management, generally result in overall cost savings through decreased adverse outcomes, such as emergency room visits, hospitalizations, and death, but may appropriately increase drug utilization for undertreated conditions.

Senior Care: Navigating the Medicare Maze

By Stephanie Kiser, RPh
Director, Mission Medication Assistance Program For Seniors,
Mission Hospitals and Clinics

Imagine for a moment that you are in a maze. You cannot see over the top, you cannot see around to the next corner, you continuously run into road blocks and have to go back to your starting point. This is exactly how I felt last week as I attempted to navigate the "Medicare Maze." I went to the Medicare Web site hoping to find useful information to share with my patients and colleagues related to the new Discount Cards. I spent well over an hour and when finished, I knew the same amount of information as when I had begun my cyberspace venture. My frustrations related to all the upcoming Medicare changes, including the Discount Card program, are difficult to express.

I currently serve as the Director of Mission Hospital's Medication Assistance Program for Seniors. Our program exists to assist low-income seniors in obtaining their medications along with providing pharmaceutical care and disease state manage-

(Continued on page 12)

ment services. We pride ourselves in helping seniors make the most cost effective decisions in obtaining their medications. As Medicare rolls out its programs for seniors, we realize that our ability to be good navigators becomes greatly impaired. My staff and I spend copious amounts of time searching for good information to assist seniors and often come up empty handed. The fact that the Discount Cards are being talked about at length in the media and on the Medicare Web site makes the situation even more difficult, prompting seniors in our area to call our office for help. With the roll out of the Discount Cards, we will spend enormous amounts of time explaining the details. In short, we will have to tell patients that the cards are not available until June, we have no idea which medications they will cover or what percent of savings they will have, we do not know which pharmacies will accept them, and we have no idea how they may affect the drug manufacturer assistance programs.

The Discount Card and upcoming Medicare changes make some assumptions about seniors that will likely be detrimental to the success of the program. The existing information I found is geared toward seniors with a high literacy level and access to computers. In reality, a large number of our patients have low literacy rates, no access to computers, and don't know how to "surf the Web." In our program, the staff often helps patients in every step of the assistance process. There are many instances when our patients even bring their Medicare related mail to us for understanding.

A personal concern arose while searching several Web sites related to their advice to patients. One of the suggestions is to "ask your pharmacist" which card is right for you. If the pharmacist cannot get good information, what are our senior patients going to do? Recognizing the current working conditions of most pharmacists in North Carolina and the country, I am greatly concerned for our patients. Where will they go to get the information they need? Pharmacists barely have time to meet medication-counseling requirements. I cannot see how they will have the time needed to explain this complicated system to our seniors unless more adequate information is provided before the program is implemented.

I would like to end with what I feel is the most important question that stems from this: "Who will help our seniors navigate the Medicare Maze?" My hope is in the coming months this will be answered, for the sake of our patients and their health.

Seniors' Health Insurance Information Program

By Carla Obiol
Deputy Commissioner,
Seniors' Health Insurance Information Program (SHIIP), NC Dept. of Insurance

Insurance made big news at the end of 2003 when the President signed the Medicare Prescription Drug Improvement and Modernization Act (MMA) into law. This new legislation, the culmination of years of debate, adds much-talked-about prescription drug coverage to Medicare. While maintaining the current Medicare program, the MMA adds optional coverage for prescription drugs and preventive benefits and provides extra help to people with low incomes.

But why does this concern you as a pharmacist? Well, for one thing, chances are you have a lot of customers, or their family members, who are Medicare beneficiaries and they will be affected by these changes. Because you are a trusted medical professional, they very well may turn to you seeking help on what new prescription drug discount cards or what prescription drug coverage options are best for them. Or perhaps they will need an explanation as to how much the new discount card programs are reducing the costs of the drugs they are currently taking, and how the other discount card programs compare. You want to help your customers, but where are you supposed to find answers to their questions?

The North Carolina Department of Insurance's Seniors' Health Insurance Information Program, or SHIIP, is tracking the latest changes, and we have a full staff of experts and volunteers ready to help navigate these options and help you assist your customers. Whether your employees call us, you call us yourself, or you refer customers to us, be assured that SHIIP is here to help.

Many of you may not be familiar with SHIIP, which provides Medicare recipients with answers to their questions. Through community volunteers, expert staff and a consumer hotline,

SHIIP provides valuable information to senior citizens, their families and other Medicare beneficiaries. SHIIP hopes to expand its efforts to reach more people by increasing the training of its volunteer counselors in the state, by expansion of counseling locations in areas close to low income and hard to reach beneficiaries, and by development of materials with North Carolina specific information. The new coverage, which begins in-part in 2004 as a Discount Card Program, brings with it a whole host of new questions. It's sure to keep our people busy.

This year Medicare will provide prescription drug discount cards and transitional assistance ($600) to people needing help paying for prescription drugs. Companies that sponsor a discount card and meet Medicare's standards will have a Medicare-approved seal on their discount cards. These cards are voluntary, but almost everyone with Medicare will be eligible. This change is expected to save recipients 10 to 25 percent on their prescriptions. Of course, savings will vary and participants may not save on every medicine they need. There will be different programs and each card will provide different benefits or savings. It is important that beneficiaries understand that there will be formularies and participating pharmacy networks associated with the discount cards. All consumers will need to buy wisely, but some may find that they don't need to buy cards at all. This is where SHIIP staff and volunteers can prove helpful in navigating the tangle of new benefits. While SHIIP staff and volunteers can answer questions and give advice, they will be careful not to endorse or promote a particular product and remain impartial and objective.

North Carolina Medicaid will keep pharmacists participating in the Medicaid program updated on Medicaid changes resulting from the legislation through the Medicaid bulletin. Most importantly, pharmacists need to know that those individuals who currently receive their prescription drugs under Medicaid will not be able to participate in the discount card program.

The NC Senior Care program is evaluating options for coordinating state and federal prescription drug benefits for Senior Care eligibles in a way that will maximize their benefits and minimize confusion for both you and your customers. They expect to have more details available as implementation of the drug discount cards nears.

By 2006 when Medicare's new prescription drug benefit begins, recipients will hopefully have had a chance to educate themselves about their new benefits. Everyone with Medicare will have the option to enroll in a plan that covers prescription drugs, but these plans may vary and will be offered by private companies. The details can be confusing, so please refer the Department's services to anyone you know who may need help.

By now you're probably asking — how can I get in touch with SHIIP? To get answers to any questions about the new Medicare law or any other Medicare concerns, call us at 1-800-443-9354. This number will also put you in touch with someone who can help you locate a local SHIIP volunteer to provide counsel to you or one of your customers. SHIIP volunteers and staff are also available to speak to senior citizens groups or provide information to interested organizations. Alternatively, information can be found by visiting the SHIIP Web site at www.ncshiip.com or e-mail shiip@ncdoi.net to get questions answered online.

Designing Safer Systems

by William L. Harris

The headlines read "Two patients dead in tragic error" and the story reported that a dialysis drug mix-up was the cause. The preparation error involved the inadvertent use of potassium chloride instead of sodium chloride. A spokesman stated that "despite our best efforts, errors do occur." The role of patient safety programs is to determine how or why errors occur and make changes in the medication use system to prevent the same or similar errors from recurring.

The causes of medication errors have been grouped into three major categories: (1) system factors, (2) technical factors and (3) human factors. Many errors involve elements from all three categories due to the complexity of the medication use system. James Reason has written much material about the necessity to incorporate human factors into the analysis of errors in our efforts to improve patient safety.

While it is important to focus medication safety efforts on the systems that fail rather than on individuals who make mistakes, patient safety can benefit from analyzing the effects on health care providers by the work environment, equipment, policies, processes, products and resources in the medication use system. By incorporating the human factors approach, the human component with its limitations and capabilities can be examined to determine if medication errors can be reduced or prevented by improved working conditions and systems design. In 1996, ASHP recommended the application of human factors concepts into strategies to analyze flawed medication systems and to improve the design and operation of medication use systems.

Reason's model for analyzing industrial accidents, such as the Chernobyl nuclear reactor tragedy, has been adapted for medical settings. The approach is similar to root cause analysis in which all actions are traced back to the basic steps in each process that is involved in a medication error. The question of why or how did each breakdown occur is followed until the chain of events is fully understood. In each step, human decisions and the conditions in which they were made are examined as part of the investigation. Actions are categorized as active failures or latent failures.

Active failures may have immediate adverse patient consequences and may be slips, such as picking the wrong medication (for example, potassium chloride versus sodium chloride), or memory lapses, such as forgetting to administer a medication or to document that a medication was administered. Rule violations are more serious active failures, such as deviation from standard practice, procedures or appropriate safety checks, and may be associated with low morale, low performance motivation, poor examples from senior staff or inadequate management. Examples of rule violations include not reading computer alerts during prescription processing, not checking patient allergies before ordering or administering medications, dispensing medications without an order or pharmacist check and borrowing medications from one patient to give to another.

Latent failures result from decisions that were made by management or leaders in the organization before the medication error occurred. The decisions affect the working conditions and include inadequate knowledge or experience, heavy workloads, inadequate supervision, stress in the work area, poor communication systems, outdated equipment, resource deficiency, unsafe working environment, system design flaws and poorly defined goals. Examples of latent errors include inadequate staffing, providing equipment without safety features, product selection criteria, ignoring complaints or reports of equipment failure and ineffective communication between employees and management.

Human factors engineering seeks to identify the system problems and then change the processes to eliminate the flaws and unsafe work conditions. The goal is to eliminate poor design, unclear procedures, inadequate training, hazards, environmental noise, distractions or any conditions in which the employee cannot focus on the work at hand. Performance, safety and output will increase when employees, tasks, resources and equipment are matched appropriately.

Human performance can be classified into three levels of cognition: (1) skill-based, (2) rule-based and (3) knowledge-based. Skill-based cognition refers to thought and actions that are automatic after they are easily learned, such as general hygiene, driving to work and other activities that we do routinely and automatically without instructions. Skill-based errors are unintended acts and may occur when there is inadequate skill or incorrect activation of a skill. The brain may make a faulty connection or mental association between two ideas due to an external stimulus or distraction. There may also be slips in performance or in remembering the task that is being performed. Examples include drug selection errors, delivery errors or forgetting to send a medication dose as promised.

Rule-based cognition refers to solving problems based on past experience, explicit instructions and applications of a specific rule when specific conditions are encountered. The rules are learned through application and training, and correct solutions are learned for best practices in patient care (for example, if condition x occurs, then apply solution y). Rule-based errors occur when the wrong rule is chosen or there is misapplication of the rule (misinterpretation or faulty perception of the situation). For example, the wrong medication may be ordered or the medication may not be best for this patient.

Knowledge-based cognition is applied for novel situations when rule-based solutions do not resolve the problem. This requires conscious analytical processing and the use of acquired information stored in memory or obtained from external sources. Knowledge-based errors usually involve complex situations in which the practitioner lacks the necessary knowledge or misapplies the knowledge to the situation encountered.

Physiological, psychological and environmental factors may adversely affect all types of cognition and performance. Physiological factors include fatigue, sleep loss, effects of medications and alcohol, illness, poor eyesight or diminished senses, long shifts or working back to back shifts. Psychological factors include frustration, tension, anger, fear, anxiety, boredom, overwork, interpersonal relations or emotional stressors. Environmental factors include temperature, light, noise, dirty conditions, equipment problems, distractions, odors and inadequate work space. Reason reported that slips are the most common human errors since many of our activities are automatic, but errors in knowledge-based processes are more significant.

Table 1: Cognitive Errors and Associative Conditions

Skill-based Errors

- Slips and memory lapses
- Inattention, busy, multi-tasking
- Fatigue, sleep loss, medication side effects
- Distractions, environmental factors
- Monitoring failures
- Doses not administered
- Documentation failure
- Picking wrong medication
- Giving medication to wrong patient
- Changing rate on wrong pump

Rule-based errors

- Misunderstanding of patient condition
- Wrong drug choice for patient or condition
- Inadequate training
- Lack of experience
- Override alerts and disregard warnings
- Borrowing another patient's medication
- Failure to adjust dose for clinical setting
- Failure to follow medication use guidelines
- Work around process or cut corners in checks
- Application of wrong rule for situation

Knowledge-based errors

- Complex situations in which rule-based solutions are not effective
- Novel problem in which no rule-based answer is known by practitioner
- Stress to do something
- Situation is not completely understood (lack of pertinent information)
- Biased memory of previous situations that may be different
- Overgeneralization of the problem
- Lack of experience may lead to wrong conclusion
- Confirmation bias (seek evidence to validate initial working hypothesis)
- Use first information that comes to mind without thorough assessment
- Overconfidence

The literature indicates that human factors are involved in many preventable medication errors. Leape reported that lack of drug knowledge was involved in 22% of medication errors, lack of patient information in 14%, rule violations in 10%, slips and memory lapses in 9%, faulty drug checking in 7%, faulty interaction with other services in 5%, faulty dose checking in 5%, inadequate patient monitoring in 4% and preparation errors in 3%. This includes 79% of the preventable medication errors described in this study.

Leape also reported that in prescribing breakdowns, 60% of errors were related to lack of drug or patient information, rule violations were involved in 19% of orders, slips or memory lapses were involved in 11% and inadequate monitoring was attributed to 8% of medication errors. For drug administration errors, lack of drug knowledge was attributed to 15% of errors, improper device use in 13%, slips or memory lapses were involved in 12%, faulty drug checking in 10%, faulty dose checking in 10%, lack of patient information in 10% and ineffective communication in 10%. Slips and memory lapses were associated with 73% of the transcription errors. Lack of drug knowledge and incomplete patient information were involved in 25% of transcription errors. Slips and faulty drug identification with sound-alike or look-alike drug names and packaging were listed in 29% of pharmacy preparation and dispensing errors.

Phillips reported that human factors were involved in 65% of preventable medication errors related to patient mortalities. The root causes of these errors included performance deficit in drug administration (29.8%), knowledge deficit (14.2%), dose miscalculation (13%), drug preparation errors (5.8%) and other human factors (2.2%).

Kanjanarat summarized the results of four preventable adverse drug events (ADE's) studies and found that lack of drug knowledge was associated with 22.4% of dose errors, inappropriate drug use or wrong drug choice errors occurred in 17% of medication errors and 16.5% involved drug administration errors. Inadequate or lack of patient monitoring was involved in 12% of the errors and administration of medication to patient with a known allergy to the medication occurred in 6.9% of cases.

Data from the MedMARx national program for medication error reporting indicates that human factors were involved in the majority of reports, such as performance deficit in 39%, rule violation in 17%, knowledge deficit in 10%, inaccurate or omitted documentation in 9% and confusing or intimidating communication in 8% of reports. These results were based on reports received through August, 2000.

Rothschild analyzed the reports for preventable ADE's related to malpractice claims and listed the types of human factor failures identified. Operational system failures included poor team communication (48% of cases), inadequate handoffs of relevant information (23%), supervisory failures (16%), inadequately trained staff (16%), ergonomic deficiencies (16%) and failure to appropriately use consultants (10%). Organizational or managerial system failures included poor interdisciplinary communication (30% of cases) and use of substitute or inexperienced professionals (23%). Design failures included system complexity (24% of cases) and deficient automation or technology design (14%). Individual human performance errors included knowledge-based errors in 57% of preventable ADE's, skill-based errors in 49% and rule-based errors in 20% of the events.

(Continued on page 16)

Designing safer medication systems requires the use of all available medication error information and effective analysis techniques. Human factors engineering examines human performance not to place the blame on individuals that fail, but to understand how to improve the systems in which we work. Three goals established in this approach include: (1) design systems to prevent errors, (2) design procedures and safety systems to detect and intercept errors that occur and (3) design procedures and safety systems to mitigate the adverse patient effects when medication errors reach the patient.

Reason stated that "We can't change the human condition, but we can change the conditions under which humans work." Medication error investigation must include effective interviews with the health professionals involved in order to gather the unique details of each event and to understand the whole story of what went wrong and why it happened. Improving patient safety is a continuous process that seeks to improve the interactions between the caregiver, the equipment and resources utilized and the patient. Our best efforts are required to reduce medication errors and to prevent patient harm. ❖

About the Author...

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Threats of Drug Importation

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By Marv Shepherd, PhD, director at the Center for Pharmacoeconomic Studies, Drug Dynamics Institute, and professor and chairman at the College of Pharmacy and Pharmacy Administration at University of Texas.

Personal importation of pharmaceutical products into the United States from Mexico and Canada has been occurring for decades, if not centuries. Historically, the movement of drug products has occurred mainly in those states which border these countries, but in recent years the demand and access of imported drug products is occurring throughout the United States and more countries than just Mexico and Canada are involved. Imported drug products flowing into this country are coming from all over the world.

Today, people do not have to travel out of the country to obtain prescription drug products. They can sit in their home and order pharmaceuticals via their home computer from just about anywhere in the world. Many times they do not even need a prescription. Due to the heightened American appetite for cheap pharmaceuticals, imported drugs are flowing into the United States at an alarming rate, causing many concerns and problems for our society, patients, and healthcare practitioners.

The drug importation problem is enormous and has many fronts. Political, social, and economic patient care and safety issues combine to define the problem. To address the problem, it will require the cooperation of many state and federal governmental agencies, law enforcement agencies, private organizations, international organizations, consumer groups, and professional associations. Furthermore, it will require political groups to work together and put differences aside and address not only the economic side of the problem, but also public safety. Finally, it will take funding no matter what decisions are made.

Legality of Imported Pharmaceuticals

It is very important to understand that bringing unapproved drugs into the United States via mail or personally carrying the product into the United States is illegal (Federal Food Drug and Cosmetic Act, 21 U.S.C., Section 33). Federal Food & Drug Agency prohibits the interstate shipment of unapproved drugs. The importation of drugs, whether for personal use or otherwise, is a violation of the FFDCA. Unapproved drugs are any drug, including foreign made versions of United States approved drugs that have not been manufactured in accordance with and pursuant to FDA approval.

The only entity which can legally import pharmaceuticals is the drug manufacturer. However, FDA realizes that there may be situations where importation of an unapproved drug may be necessary and thus has established some variances of the law. These variances are as follows:

- When the intended use is unapproved and for a serious condition for which effective treatment is not available in the United States.
- There is no commercialization or promotion to persons residing in the United States by those distributing the product.
- The product does not represent an unreasonable risk.
- The patient has exhausted United States treatments and the product is not available in the United States. This drug is essentially a last attempt to treat the condition.
- The patient started the treatment outside the United States and is continuing therapy upon returning to the United States.
- The product is for personal use, not for commercial use.

It is important to realize that foreign made versions of United States drugs are not intended to be covered by these guidance variances. The FDA views unapproved foreign made versions of United States approved drugs as an unreasonable risk. In looking at the variances, one can see that compassion is expressed in the guidance and return visitors to the United States should be allowed to bring their medications with them when they visit the United States.

So, you may wonder, if it is illegal, why are so many pharmaceutical products entering the country? The answer is politics, politics, and more politics. The pressure from consumer groups, seniors, and elected officials is tremendous. Since the demand and pressures for cheaper drugs is so great, FDA has decided not to enforce the law. Drug importation is still illegal, but FDA and United States Customs are 'looking the other way' and permitting a 90-day supply of the drug product to come into the country for personal use.

The problem with this position is that we may be appeasing one sector of our population while we threaten the drug distribution system and the health and welfare of others. I commend Congress on being so attentive to their constituencies, especially the elderly and the less fortunate on their demands for cheaper drugs. But, I also believe Congress has 'lost touch' with the threats and realities of opening the border for drug importation. Congress needs to address the problem of providing access to prescription drugs for the elderly and less fortunate, but do so without jeopardizing the safety of our drug distribution system and the safety of the public.

Quality of Imported Drug Products

Most imported drug products are not FDA approved, nor are they manufactured in FDA approved facilities. In fact, drugs manufactured for foreign markets do not comply with all aspects of FDA regulations such as formulation requirements, source of ingredients, processing methods, manufacturing controls, and labeling. As a result, imported drugs may:

- contain no, too much, or the wrong active ingredient;

(Continued on page 18)

- be expired or have a false expiration date;
- be contaminated;
- have been stored under unsafe conditions such as inappropriate temperatures, excessive humidity, or extreme cold;
- be fake or counterfeit; or
- be mislabeled.

Rogue Internet Pharmacy Sites

The extent of imported drugs coming into the United States via mail or other delivery vehicles is tremendous. Last year at a U.S. House Energy and Commerce Committee open hearing on drug importation, Rep. Greenwood reported that the Miami international mail facility receives 30,000 parcels containing drugs a day. Based on those figures, the FDA estimated that 20 million packages came into the United States last year. This is an increase of more than 1000 percent in two years. Many of the parcels contained multiple drug products and exceeded the 90-day supply limitation. There are 12 such mail facilities scattered across the country. To say that FDA is overwhelmed in trying to screen and monitor the quality and type of products entering the United States is an understatement. FDA has stated that they cannot monitor nor do quality control checks for imported drugs. FDA Commissioner Mark McClelland has recently stated that it is a "buyer beware" market.[1]

The worldwide internet web-based pharmaceutical provider operations have proliferated. There are literally thousands of internet pharmacy providers worldwide, many of which are fraudulent, rogue operations. I am sure that you have received e-mail solicitations for a variety of pharmaceuticals from diet and pain killing products to sexual enhancement products. Many of these rogue sites peddle counterfeit products and most offer non-FDA approved products.

What is more frightening is that many of these rogue internet sites are operated by criminals who may be connected to drug cartels or organized crime. These rogue sites pop-up over night and disappear just as fast. Some have many affiliate sites so it is difficult to track down the original location. The site registration information for many is false and they use a deceptive internet address, such as having the name "Canada" in the Web site when in fact the site is located in another country. Furthermore, it is very difficult to determine the physical or mailing address of the site. The bottom line is that consumers are being duped into thinking that it is a legitimate pharmacy operation offering quality drug products when in reality it is far from the truth.

It can be difficult for consumers to distinguish between legitimate and illegitimate pharmacy internet providers. There are licensed, legitimate internet pharmacy providers, and such operations conduct business following strict local, state, and federal regulations, plus they have strong internal standards. The National Association of Boards of Pharmacy has developed a quality inspection process for internet pharmacy operations. If a pharmacy meets their standards, it is designated a Verified Internet Pharmacy Practice Site (VIPPS). The VIPPS designation will be on the internet pharmacy webpage for easy consumer identification. Consumers need to avoid the "rogue internet sites" and look for one of the 14 VIPPS-designated sites. For a list of approved VIPPS pharmacies go to www.nabp.net/vipps/consumer/listall.asp.

To determine the type of products coming into the United States from abroad, last summer FDA examined a sample of 1,153 imported drug products taken from four United States international mail facilities. A total of 88 percent (N=1,019) of the products were unapproved products. Some of the products were never approved by the FDA, some had inadequate labeling or were inadequately packaged, and some products had been withdrawn from the United States market for safety reasons because they require careful monitoring and screening. Other products appeared to be counterfeit. Finally, many products were controlled, narcotic substances. The products came from a wide variety of countries.[2] This survey points out that the vast majority of imported products entering the United States have the potential of causing an array of problems for consumers, healthcare practitioners, and our society.

In *The Washington Post* series of articles on drug importation, which was published the week of October 19, the article "Two Agencies to Fight Online Narcotics" should raise the concern of all Americans. This article gave a description of how easy it is to obtain narcotics via the internet. When the public, including children, can purchase illicit, dangerous habit-forming narcotics via rogue internet operations with only a credit card number

and the completion of a questionnaire, we have truly lost control of the situation.

Pharmacy Store Front Operations

Besides the growth of internet access to pharmaceuticals, a new set of operations have recently appeared in the United States and have been referred to as pharmacy store front operations. These operations are a conduit for transferring/faxing prescriptions to pharmacy providers located in Canada. Due to Canada's regulations of drug prices, drug costs in Canada are 20 to 80 percent less than the United States for selected products. Basically, patients bring their prescriptions to the store front operation; the prescription is faxed to the Canadian pharmacy provider, which fills the prescription and mails it back to the patient. Sometimes patients are required to complete a short health questionnaire. Patients must also sign a waiver form releasing their right to file suit against the Canadian pharmacy and the store front operations in case harm results from the medication.

Patients pay for the medications and are required to pay a service fee to the store front operation for the service, which is usually $15 per prescription. It is important to realize that store front operators are NOT licensed pharmacists—they are clerks faxing prescriptions to a Canadian pharmacy. Another unique regulatory problem with store fronts is that because these operations do not dispense drugs, they do not fall within the pharmacy practice regulations for many states. Thus, state boards of pharmacy are struggling with regulating such enterprises.

In Canada, it is illegal for a pharmacy to fill prescriptions written by a physician who is not licensed in Canada. Thus, to be legal, United States prescriptions need to be co-signed or re-written by a Canadian licensed physician. This also presents additional problems for many Canadian physicians because there is suppose to be an established patient-physician relationship before a prescription is written. However, this is a hotly contested issue in Canada. A spokesperson for CanaRx, a large internet pharmacy provider in Ontario said they are in "total compliance" by having a Canadian physician co-sign United States written prescriptions. While in Manitoba, four Canadian physicians were recently censored for co-signing United States prescriptions.[3] Health Canada, the governing body over pharmaceuticals in Canada, has very broad control. The control over practice lies within each province and there appears to be a wide interpretation of the regulations between provinces.

In regard to size of the Canadian drug market for Americans, various estimates exist. But one number frequently seen in the press is that 1 million Americans are now getting their drugs from Canada and the pharmaceutical market size is approximately $700 million to $1 billion. Most of these drugs are purchased through 80 to 90 Canadian internet pharmacy providers. There are also many Canadian border pharmacies which are easily reached by Americans via car or by bus and purchases from these pharmacies will increase the market size.

Pharmaceutical Industry Reaction to the American Demand for Canadian Drugs

The United States pharmaceutical manufacturing industry reaction to the increased demand by Americans for Canadian drugs has been in writing warning letters to Canadian wholesalers and distributors; some companies have been very deliberate and forceful in their letters. For example, in January 2003, GlaxoSmithKline (GSK) sent letters to Canadian drug distributors indicating that they will cease to sell drugs to them if they continued to supply drugs to Americans. Eli Lilly and Merck also sent warning letters to several Canadian pharmacies and wholesalers saying that U.S. and Canadian law prohibits the exporting of their products to the United States. (Please note, that when United States products are sold by these companies and other United States firms to Canadian distributors, the sales contract agreement states that the products are for Canadian use only.) In April 2003, AstraZeneca sent letters to Canadian distributors stating that they will cap the size of their drug shipments based on historic demands and in June Wyeth indicated that they will limit drug supplies based on last year's demand. In August, Pfizer sent letters to 50 Canadian distributors informing them that GSK's products must be purchased directly from the company instead of through a wholesaler and they may reduce shipments. Finally, in October, Eli Lilly sent letters indicating that they will also limit supplies. Thus, five major firms (GSK, Eli Lilly, AstraZeneca, Wyeth, and Pfizer) have decided to limit drug exports to Canada based on historic demands.

As expected, when the United States public heard about the restrictions, the outcry was tremendous, some called GSK a "profiteering monster." Public advertisements and announcements appeared in national newspapers against the firms. Even state legislatures passed resolutions against selected companies denouncing the supply limitation. Some Canadian internet firms have solicited a boycott against GSK's consumer products division products Tums® and Aquafresh®.

As a result of the threats of limiting supplies, there has been a proliferation of news articles speculating on the shortage of drugs for Canadians. Some Canadian authorities are worried about the threat. Canada is dependent on imported pharmaceuticals to meet their own needs, let alone supplying new United States demands. The Canadian drug market is approximately $6.4 billion. Canadian production of pharmaceuticals is $4.4 billion, but they export $1.7 billion of what they produce. Last year, the United States drug exports to Canada were $2.4 billion. This leaves a deficit of $1.2 billion, which is made up by Canada importing drugs from other countries and these drug imports satisfy the Canadian own-use demand, not the United States demand for Canadian drugs. To meet the increasing United States demand for pharmaceuticals, Canada will rely upon additional imports.

FDA Reaction

FDA is on record as saying that they were not going to prosecute individuals getting their pharmaceuticals from out-of-the-country. In other words, they would not arrest "grandma" for importing drugs for personal use. FDA did state that they would pursue those companies or organizations which facilitate the illegal importation of pharmaceutical products.[4] In September of 2003, the Department of Justice filed an injunction in Tulsa, Oklahoma against Rx Depot for operating an alleged illegal "store front" operation.

(Continued on page 20)

Rx Depot had 86 stores in 26 states. On November 10, 2003, Federal Judge, Clare Eagan granted FDA's request to shut down Rx Depot. Judge Eagan stated, "This court is not unsympathetic to the predicament faced by individuals who cannot afford their prescription drugs at U.S. prices, however, the defendants are able to lower prices only because they facilitate illegal activity determined by Congress to harm public interests.[5]"

Working with the state boards of pharmacy in Oklahoma and Arkansas, FDA has sent cease and desist letters to "store front" operations, states, and municipalities to discourage their drug importation plans and activities. Springfield, Massachusetts is the only city which has contracted with a Canadian internet provider to obtain prescription drugs for city employees. States currently exploring the idea of importing Canadian drugs are California, Illinois, Massachusetts, Wisconsin, Michigan, Minnesota, Maine, Vermont, and Iowa.

In response to the growth in interests by government entities, the six major Canadian pharmacy internet firms formed an alliance called the Super Six Canadian Pharmacies. The Super Six claim that they currently serve 1 million Americans and say that their combined resources will ensure that any state or city that wants Canadian drugs can get them. Daren Jorgenson, spokesperson for the Super Six stated: "...the six member pharmacies, all licensed by Canadian provinces, would get drugs from other countries if U.S. supplies tighten or if U.S. drug makers restrict sales."

Many Canadians have stated that all the products being shipped to the United States are approved by Health Canada. However, Canadian officials have stated that they will not "guarantee" the safety of the drugs that cross the border into the United States.[6] If the United States demand continues to escalate and drug shortages occur in Canada two possibilities exist. First, a Canadian governmental entity may step in and stop the shipment of drugs to the United States. As pointed out, this will be difficult due to the provincial control over pharmacy practice. The second possibility is that Canada, mainly the internet drug firms, will find other secondary foreign drug suppliers. In other words, they will find other off-shore drug suppliers. This will raise drug quality questions and raise concerns for the entry of drug counterfeit products. Currently, Canada is importing pharmaceuticals from more than 100 different countries, including China, Ecuador, Mexico, Argentina, India, and Singapore. In fact, when comparing the first nine months of 2002 with the first nine months of 2003, Canadian pharmaceutical imports from China have increased 38 percent, imports from South Africa increased 98 percent, and an increase of 292 percent from Ecuador. Drug imports from the United States have increased 24 percent. Overall, Canadian pharmaceutical imports have increased 24 percent from $3.3 billion to $4.1 billion from January through August 2003.[7]

Counterfeit Drugs and Drug Importation

Counterfeit drugs are defined by the World Health Organization (WHO) as a drug which is deliberately and fraudulently mislabeled with respect to identity and/or source. It can apply to both brand and generic products and it may include products with correct active ingredients, or wrong active ingredients, without active ingredients, with insufficient active ingredients, or with false packaging. Counterfeit drugs are a growing problem worldwide. This year FDA has opened 22 counterfeit drug cases. Two years ago there were only five cases. WHO estimates that eight percent of the world pharmaceutical market is counterfeit; it is estimated to be a $40 billion market. However, in some countries in Latin America, Africa, and Asia, counterfeit drugs comprise 40 to 60 percent of the market.

A strong argument can be made that allowing drug importation for all over the world opens up the door wider for the entry of counterfeit pharmaceuticals into the United States. This threatens the health of Americans and threatens the integrity of our drug distribution system.

Conclusion

As one can see, drug importation is a very controversial and political issue. The American appetite for affordable medications continues to grow. Our elderly are demanding access to cheaper pharmaceuticals and politicians are listening to their demands. However, drug importation is not the solution to the problem. Drug importation threatens the integrity of our drug distribution system, which in turn threatens public health and safety.

A step forward to the access problem of prescription drugs for our elderly is the passage of a Medicare prescription drug plan. Depending on the prescription drug plan specifics, it may relieve the consumer pressure on legislators and cut back on the demand for imported drugs. The bottom line is this country needs to address a prescription drug plan for our elderly; we need to ease the burden of access and drug cost for the elderly. Lastly, we need to halt or put severe restrictions on the importation of pharmaceuticals. If we do not, I predict as a society we will be paying more in the end, not only in healthcare costs, but in disabilities and lives. ❖

1 Welch, William, "Once Just a Trickle, Canada's Rx Drugs Pouring into USA" USAToday.com. Accessed October 7, 2003.
2 "FDA/U.S. Customs Import Blitz Exams Reveal Hundreds of Potentially Dangerous Imported Drug Shipments," www.FDA.gov/bbs/topics/NEWS2003/. Accessed September 30, 2003.
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4 "FDA Threatens Stores That Sell Canadian Drugs to U.S. Residents" www.USAToday.com/money/industries/health/drugs/2003-04-08-canadadrugs_x.htm. Accessed April 14, 2003.
5 "Judge Orders Internet Drug Firm Closed," CNN.com/2003/health/11/06/Canada.drugs/index.html. Accessed November 7, 2003.
6 www.safemedicines.org/resources/healthcanada.html. Accessed September 22, 2003
7 http://Strategis.gc.ca/sc_mrkt/. Accessed November 5, 2003

Important Dates to Remember:

- ✔ April 26-28: NCAP Acute Care Practice Forum Meeting (formerly NCAP Spring Meeting), Sheraton Greensboro Hotel at Four Seasons/Koury Convention Center
- ✔ June 16: Pharmacy Day in the Legislature.

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UNC Professor Wins Weiderholt Prize

Carole Cranor, RPh, PhD, is the winner of the Weiderholt Prize in the Pharmaceutical Sciences for the best paper published in the *Journal of the American Pharmacists Association* in the area of economic, social, or administrative sciences, for "The Asheville Project: Short-term Outcomes of a Community Pharmacy Diabetes Care Program." The APhA Academy of Pharmaceutical Research and Science awards are given annually to individuals or organizations for extraordinary achievement in the pharmaceutical sciences. She accepted the award on behalf of her co-authors, Barry Bunting and Dale Christensen, the pharmacists who helped provide the outcomes reported in the article, the City of Asheville, and Mission St. Joseph's Health System. She obtained her master's degree in pharmacy administration and earned a PhD in health policy and administration from the University of North Carolina-Chapel Hill. Currently she works as Research Assistant Professor, Division of Pharmaceutical Policy and Evaluative Sciences, UNC-CH School of Pharmacy.

2004 Calendar

April 7: ***Update on NC Pharmacy 2004,*** Greensboro AHEC. Free, live CE. Sponsored by NCAP, the NC Board of Pharmacy, UNC, Campbell U. and Wingate U. Schools of Pharmacy. For registration information call NCAP.

April 13: ***Update on NC Pharmacy 2004,*** RTP, NC. Free, live CE. Sponsored by NCAP, the NC Board of Pharmacy, UNC, Campbell U. and Wingate U. Schools of Pharmacy. For registration information call NCAP.

April 17: ***Pharmacy Student Leaders Forum.*** Student leaders from the three schools of pharmacy will meet at the Institute of Pharmacy in Chapel Hill.

April 26-28: ***NCAP Acute Care Practice Forum Meeting (formerly NCAP Spring Meeting)*** Sheraton Greensboro Hotel, Four Seasons/Koury Convention Center. Excellent speakers, CE and networking opportunities.

May 1: ***NCAP Council Meeting Day.*** NCAP Board, Council and Committee orientation followed by meetings at the Institute of Pharmacy in Chapel Hill.

May 3: ***Update on NC Pharmacy 2004,*** Monroe, NC. Free, live CE. Sponsored by NCAP, the NC Board of Pharmacy, UNC, Campbell U. and Wingate U. Schools of Pharmacy. For registration information call NCAP.

May 6: ***Update on NC Pharmacy 2004,*** Asheville, NC. Free, live CE. Sponsored by NCAP, the NC Board of Pharmacy, UNC, Campbell U. and Wingate U. Schools of Pharmacy. For registration information call NCAP.

May 11: ***Update on NC Pharmacy 2004,*** Greenville, NC. Free, live CE. Sponsored by NCAP, the NC Board of Pharmacy, UNC, Campbell U. and Wingate U. Schools of Pharmacy. For registration information call NCAP.

May 27: ***Update on NC Pharmacy 2004,*** Fayetteville, NC. Free, live CE. Sponsored by NCAP, the NC Board of Pharmacy, UNC, Campbell U. and Wingate U. Schools of Pharmacy. For registration information call NCAP.

June 16: ***Pharmacy Day in the Legislature.*** An opportunity for pharmacists to meet with their legislators and attend a reception in Raleigh at the North Carolina Museum of History.

July 16: ***NC Pharmacy Residents Conference,*** Friday Center, Chapel Hill.

September 10-12: ***Pharmacy Practice Seminar (Ambulatory Care Practice Forum Meeting)*** Wilmington Hilton, Wilmington, NC.

October 25-27: ***NCAP Annual Convention,*** Sheraton Imperial, Research Triangle Park, NC.

For more information about these events visit www.ncpharmacists.org or call NCAP at 919-967-2237.

NCAP Donates $1,900 to CU for Compounding Program Scholarships

NCAP Executive Director Fred Eckel (center) visited the Campbell University campus on February 12 and presented a check to the Association of Student Pharmacy to help support 19 students who will attend the Professional Compounding Centers of America Compounding Program this summer in Houston, TX. NCAP contributed $100 for each NCAP student member. Accepting the check is Jennifer Crist (left), ASP President, and Pam Coley (right), 2006 Class President.

NCAP presents a great opportunity for technicians in your pharmacy...

North Carolina Association of Pharmacists
Technician Review Seminar

This one-day review has something for all technicians:

- ✔ **Prepare for the Pharmacy Technician Certification Board Exam.**
- ✔ **If you are already certified, earn 7 hours of CE credit.**
- ✔ **As of July 1, 2002 the Board of Pharmacy requires that all new technicians complete a formal training program. This course fully meets the BOP training requirements.**

NOTE: May 21 is the deadline to register for the July 17, 2004 PTCB Exam. To receive a PTCB Exam registration packet call NCAP at 919-967-2237, visit www.ptcb.org or call PTCB at 202-429-7576.

The availability of a review class prior to taking an exam is an advantage that most people would welcome. With new legislation recognizing the benefits of national certification of technicians, the advantages that this program provides will far exceed the minimal costs involved.

Over 98% of the Technicians who have taken this review course have passed the PTCB exam.

These success stories speak highly of the presentation materials and the instructors:

- Ted Spader, RPh, MSPhAd is employed with the Eckerd Corporation. He has worked at Somerset Medical Center, is the previous owner of Ringoes Pharmacy, Inc. and was previously a District Manager with Eckerd.
- Mark Sheppard, RPh is a Corporate Trainer with the Eckerd Corporation.

The NCAP Technician Review Seminar includes: • preparation for exam day • one hour of pharmacy law • basic math • dispensing calculations • hospital calculations • commercial calculations • hospital practice review • a review of the top 200 most widely used drugs including side effects, interactions and counseling tips

NCAP TECHNICIAN REVIEW SEMINAR REGISTRATION FORM

Please REGISTER AT LEAST 7 DAYS PRIOR TO THE PROGRAM you wish to attend or CALL FOR AVAILABILITY.

The review will be held from **8:30am to 5:00 pm** with a one-hour break for lunch (on your own). Please bring a calculator and a pencil.

CHECK THE LOCATION AND DATE you plan to attend:

- ❒ ***June 26, Fayetteville***, Continuing Ed. Center, Rm. 118, Fayetteville Tech Community College
- ❒ ***June 27, Greensboro,*** Moses Cone Hospital/AHEC
- ❒ ***July 10, Charoltte***, CMC-Mercy Hospital, Auditorium
- ❒ ***July 11, Asheville***, Asheville-Buncome Tech Community College

CONFIRMATION & DIRECTIONS WILL BE MAILED TO YOU WHEN REGISTRATION AND PAYMENT IS RECEIVED.

Mail registration and payment to:
NCAP Tech Review, 109 Church Street, Chapel Hill, NC 27516
or fax registration with credit card # to: 919-968-9430

If required enrollment is not met, programs will be shifted to the next closest site. For more information call 919-967-2237 or visit www.ncpharmacists.org

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North Carolina Pharmacist

Volume 84, Number 3 ...applying drug knowledge to improve health Summer, 2004

ROBOTIC DISPENSING

Dates to remember: Pharmacy Practice Seminar Sept. 10-12, Wilmington • NCAP Convention Oct. 25-27, RTP

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North Carolina Pharmacist

Volume 84, Number 3 ...opplying drug knowledge to improve health Summer, 2004

Inside

Fred Eckel
Executive Director

2004: *"Year of the Pharmacist"*

At the APhA Convention, keynote speaker U.S. Surgeon General Vice Admiral Richard Carmona, MD, MPH called 2004 the "Year of the Pharmacist" as he acknowledged that "The nation is indebted to pharmacists for protecting the public health." It is nice to have someone from outside the profession acknowledge what most of us have realized for years. Pharmacists work "behind the scenes" to protect patients and prevent problems. Many consumers do not realize the importance of this "protective role" pharmacists play. We have to keep telling our story even as government agencies and legislatures want to keep cutting our fees. We have to stay focused on the issue even though it is frustrating at times.

That is the reason NCAP and its sponsoring organizations have made Pharmacy Day in the Legislature an annual event. Pharmacy is political, whether we like it or not. If we don't step up to the plate by letting our opinions be heard and getting involved financially, we can't complain when our position is not supported. Political influence is not a sprint, but a marathon, so pharmacists must stay involved. Employee pharmacists must realize that they have a stake in this issue too. I was disappointed that few employee pharmacists were active participants in our Legislative Day.

Thank you for your contributions to the "Looks Can Be Deceiving" campaign. Community pharmacists are distributing over half a million pieces of literature warning patients of the dangers of internet-based unregulated pharmacy operations. We had some very positive coverage from our press conference. This is another issue where the community pharmacist role is under-appreciated. A former dean of mine said that we have the best drug distribution system in the world, but we may only appreciate it after it is gone. Let's work together to keep this from happening.

On another front, NCAP has been working with the State Health Plan to pilot a Polypharmacy Project in Durham and Orange Counties. The project will start this summer. If successful, the program should be implemented statewide, providing further evidence of the contribution of pharmacists. NCAP has also been helping CPP's achieve reimbursement under Medicare. Whether successful or not in this Federal legislation effort, we have to stay the course until all pharmacists achieve appropriate reimbursement for their clinical efforts.

> *"Political influence is not a sprint, but a marathon, so pharmacists must stay involved."*

With your help I hope to strengthen NCAP so we can make this the "decade of the pharmacist" in North Carolina. We can only make this happen as we work together. Thank you for your membership support. Please help us enlist more members so we have the resources needed to make that happen.

On a different note, a colleague and friend of mine has felt that we have been misleading the public as pharmacists with the "artificial" expiration dates put on the prescription label. He has created a Web site to tell his story. Gerald is very passionate about this issue. I quote from his e-mail to me:

"As a pharmacist, I believe it is my obligation and responsibility to provide dependable information to my patients. When the state of Florida required pharmacists to warn our patients to 'discard' their private property, their private medicines, after the manufacturer's expiration date, or even at a shorter period of time, I thought it proper to find out what the truth was regarding the dates. It took me ten years to find out what I and all pharmacists should know, and the information finally came from a newspaper reporter and not from any agency or pharmacy educator or leader.

Now, four years after that newspaper information was provided to the public, I find that most pharmacists still do not know the facts about expiration dates.

I have developed a Web site using documents from the FDA and other sources that outline the matter and ask that you, after validating the information and sources, provide the Web site address to NCAP members.

A thorough treatise on the background of the matter was printed in the journal U.S. Pharmacist *dated April 1985, entitled Pharmacy Law-Regulations Pertaining to Expiration Dating of Drug Products. I am presently awaiting authorization from that magazine to put it on my site, and if you can't get a copy of it, please let me know and I'll mail you a copy.*

My concern is that presently in 18 states, including North Carolina, pharmacists are being required to provide unsubstantiated information to their trusting patients.

May I suggest that you provide the address of the Web site to your members: www.expirationdates.info."

- Gerald Murphy, RPh, Florida

North Carolina Association of Pharmacists
109 Church Street
Chapel Hill, NC 27516
phone 919 967 2237 • fax 919 968 9430

Mark Gregory
President, NCAP

Dear NCAP Members,

How did this get so complicated?

Prescription Fulfillment:
Technician ratios, robotics, pharmacy workflow, DAW codes, IVR, e-prescribing, preferred drug lists, tiered copays, prior authorizations, coordination of benefits…

Patient/Pharmacist Education:
Medication therapy management, OBRA, pharmaceutical care, disease management, polypharmacy, DUR, CPP…

Pharmaceuticals:
SSRI, PPI, NSA, Ace Inhibitors, OTC's, generics, brands, branded-generics, MSB, SSB, NTI's, compounds, biotech, patent protection, blockbuster, DTC, reclamation, pipelines…

Pharmacy Provider Economics:
340B, rebates, AWPs, MACS, WACS, ASPs , usual and customary, any willing provider, most favored nations, discount cards, PBMs, chain stores, independents, mass merchants, grocery combos, mail order, marketshare, pharmacist shortage…

Rules and regulations:
HHS, FDA, OIG, CMS, DEA, SBI, NCPDP, OCR, Board of Pharmacy…

Current Issues:
HIPAA, Medicare endorsed discount cards, reimportation, internet pharmacy, pedigree papers…

Associations:
NCPA, APhA, ASHP, ASCP, NACDS, PTCB…

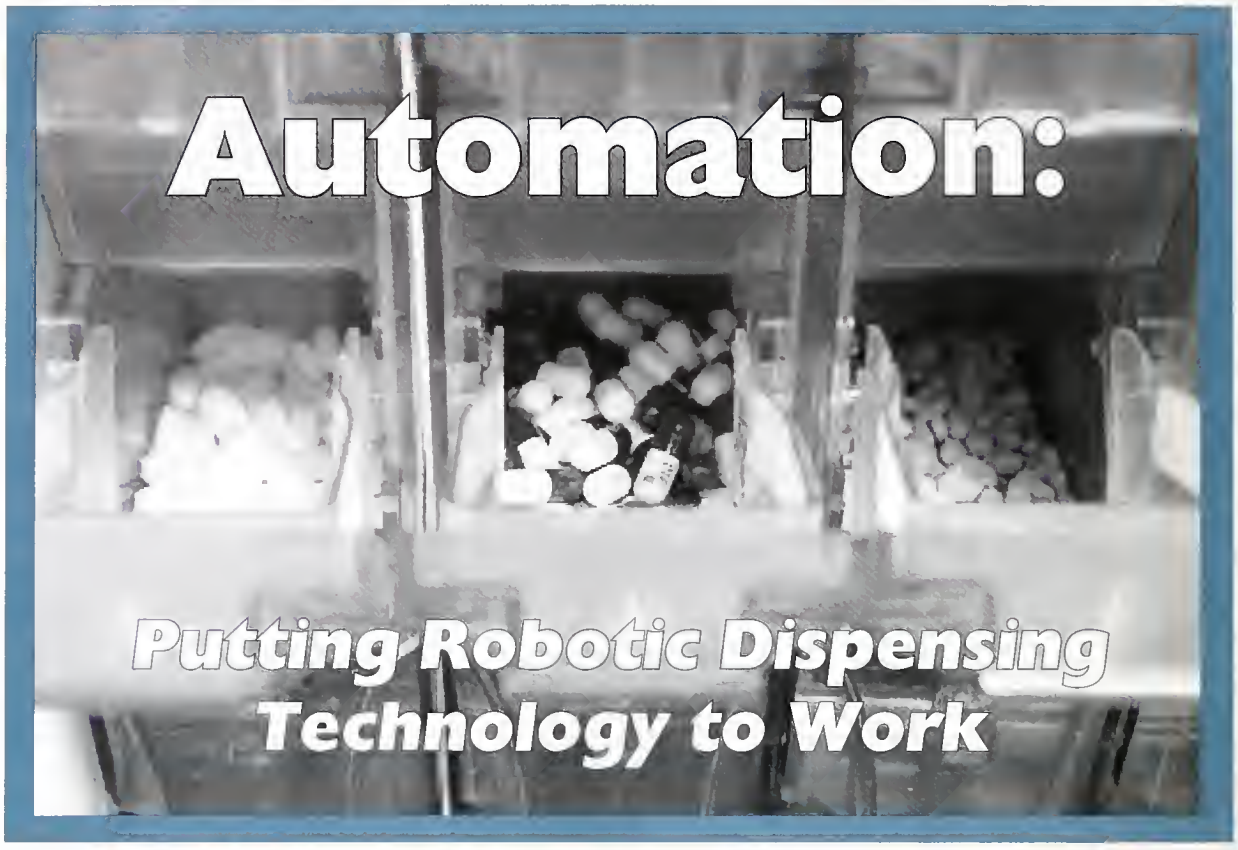
How to stay connected in North Carolina:

NCAP

Get involved!

Mark Gregory, RPh
President, NCAP

…applying drug knowledge to improve health



Automation:

Putting Robotic Dispensing Technology to Work

by Ryan Hoskins

The first thing that catches your eye when you enter Archdale Drug is the old-fashioned soda fountain at the front of the store. That soda fountain captures the spirit of our pharmacy. We want to be a friendly, welcoming place where we not only know patients' names but their healthcare needs and probably those of their families too.

Our pharmacy practice is differentiated by the high-quality patient care and support we provide. As a small town pharmacy we are on a first-name basis with most of our regular patients. They choose our pharmacy because we take time to discuss their healthcare needs, including the specific considerations of any drug treatments they have been prescribed. Though we're surrounded by chain pharmacies, our pharmacy's growth rate, about 25 percent a year, is testament that our approach is working.

In early 2003, however, we were struggling to keep up. We didn't want to change our staff or service, but our employees were becoming taxed. In a 10-hour day we had more work than we could get done. I was looking at hiring another pharmacist and another tech when we discovered another opportunity: robotic dispensing technology.

We were aware of earlier generations of the technology, but were persuaded to implement robotic dispensing largely because the compact size of the Parata RDS (Robotic Dispensing System) meant it would fit our pharmacy layout without disruption or renovation. It literally rolled in our front door and replaced just a standard shelving unit. It even plugged into a dedicated, standard outlet.

Parata RDS is a prescription workhorse. It offset more than half of our pharmacy's overall prescription volume. It processes a prescription in just 20 seconds, a cycle time that includes selecting and labeling a vial, filling, capping and sorting by patient last name.

The new robotic dispensing system also improved my peace of mind about the accuracy of our prescription filling. The Parata safety system, which uses NDC bar-code scanning, significantly reduces the risk of mistakes. Checks still occur, only they now include a technician, Parata and me. I definitely think any risk of errors is on the decline.

Our decision to implement this technology was also helped by the Federal Job Creation and Worker Assistance Act of 2002, which offers a significant tax benefit for such capital investments.

We have not touched our capacity yet. This time last year we averaged 450 scripts a day; we now average 575-600. I think we can sustain 700 scripts a day without changing a thing.

Last year Archdale's highest daily record was 800 prescriptions. Within six months of installing the system, the pharmacy hit a new record of 1,100 and has now gone over 800 about a dozen times. That volume used to be a nightmare day; now it just feels like a regular, busy day.

Employees spend more time interacting with customers. Technicians have more time to do other things as well; for example, processing an order from the

wholesaler can be done by noon, rather than after 5 p.m.

Our customers cannot believe they are getting their scripts in three or four minutes, instead of our former 20-minute wait or waits of more than an hour at nearby competitors. Our customers are expressing their satisfaction not only to us, but also to their friends. This word-of-mouth has helped drive a 20 percent increase in Archdale's business in a six-month period.

My expectation when I installed a robotic dispensing system was simply to catch up. I was at work every day, often until late at night. I now have more time off, working only about 36-38 hours a week. At the same time our business has grown 20 percent in the last six months.

Even with our increased business volume, Archdale Drug anticipates maintaining its current staff for three to four more years before needing to make additional hires. Additionally, the time to return on investment was about half of what we estimate when hiring a full-time pharmacist.

The unit has made things so much smoother. From cashiers to pharmacists, no one wants to go back to the way things were prior to installing the system.

Many pharmacists wait until they think they're ready to automate. If you can afford it, do it now so you can be prepared for the growth when it comes. Patient wait times will be lessened, as will prescription errors. ❖

About the Author...

Ryan Haskins, RPh, is the owner of Archdale Drug in Archdale, NC. He can be reached via e-mail at rhaskins@narthstate.net

Ryan Hoskins of Archdale Drug with his new robotic dispensing system.

North Carolina's Home-Grown Innovation Puts Pharmacists Out in Front

Parata Systems LLC was founded in 2001 in Durham to enhance retail pharmacy productivity with a robotic dispensing solution that is smaller, faster and more productive for retail pharmacies. Its product testing was conducted with North Carolina pharmacies, including Medicap in Burlington and Archdale Drug in Archdale. And Parata's solution is quality manufactured under strict ISO standards by Flextronics near Research Triangle Park. Now, three years later, North Carolina has a success story on its hands.

Parata introduced Parata RDS (Robotic Dispensing System) in mid-2003 and expects to sell more than 1,200 units by year-end. The Parata RDS processes a prescription in just 20 seconds, a cycle time that includes selecting and labeling a vial, filling, capping and sorting by patient last name.

"Our management team leveraged more than 50 years of pharmacy automation expertise with the idea that we could find a better way to meet the retail pharmacies' need for increased productivity," Pete Klein, Vice President, Industry Relations, said. "We began by making a machine small enough to fit in the confined spaces of most retail settings. Smaller, faster and better; our goal was clear cut."

An Easy Fit

At just 12 square feet Parata RDS fits, replacing just a standard shelving unit. This is a significant advance when you consider that part of the cost of earlier generations of automation included renovation of the pharmacy to accommodate the large equipment sizes.

Its 252 dispensing cells hold any size tablet and can be replenished without interrupting operation. On-site calibration makes it easy to change the medication load in response to pharmacy demand.

"I did not want to rearrange my entire pharmacy to accommodate new technology. If it didn't fit my pharmacy layout, I didn't care if it could do back flips," Ryan Hoskins, RPh, owner of Archdale Drug, explains.

"I could see the volumes just continuing to grow, and with the baby boomers aging it's only going to get busier," said David Smith, RPh, owner of Burlington-based Medicap pharmacy. "I was trying to position myself to capture that growth. With my building size, I knew I needed automation to make it work."

Enhancing Performance

The high prescription processing speeds of Parata RDS enable the machine to offload more than half of a pharmacy's prescriptions, allowing pharmacists to spend more time providing patient care; reducing the pressure to constantly hire new staff to handle increasing prescription volumes; and freeing capacity to explore new business opportunities.

"Last Tuesday we did 525 prescriptions and I was out front talking with patients all afternoon; I never filled a prescription," Smith explains. "Now we're selling diabetic shoes. We fitted two people for diabetic shoes on Monday. I'm able to use my techs to do other things that make their jobs more enjoyable and make this the kind of full-service, value-added pharmacy that you can't get anywhere else."

continued on page 8

Improving Quality of Life

With less time spent filling and checking prescriptions, Parata RDS helps community pharmacists reduce stress in the pharmacy and make quality of life gains outside.

"I'm taking more time off," said Smith. "I'm not there this morning. I won't be there tomorrow morning and I'm off Fridays. Three years ago I was working five days a week, and I would attribute part of that at least directly to Parata."

"I go home at night more at ease. I definitely think any risk of errors is on the decline," says Hoskins.

Breakaway Features

- Dispenses directly into the vial. No risk of cross-contamination.
- The only automation that caps all vials.
- Sorts scripts by patient name.
- Calibration can be performed on-site by user.
- Drugs are replenished without interrupting operation.
- Installation time under one hour.

Getting on the Fast Track

Parata RDS rolls in, plugs into a standard outlet and quickly begins to deliver value. Parata provides training and support to help all employees get up to speed with how to use the Parata RDS and how to ensure pharmacies get the full value from the investment. ❖

About Parata Systems...

Founded in 2001, Durham, NC-based Parata Systems LLC delivers breakaway prescription-automation performance. For more information visit www.parotasystems.com, e-mail info@paratasystems.com, or call 1-877-727-2821, x 200.

Parata RDS fits in tight workplaces.

Performance Metrics of Parata RDS:

Performance	"Score"	Business Impact
Counting speed	25 tablets/sec.	Enhances prescription productivity and pharmacy capacity.
Filling speed	1 script/20 sec. Approximately 150 scripts/hr.	Cycle time is for a "complete prescription," labeled, capped and sorted by patient last name.
Size	12 sq. ft., 26Wx72Lx77H	Compact size equals simplicity in installation and operation. Enables rapid, smooth workflow, even in tight workspaces.
Capacity	252 cells	Large capacity accommodates up to half of store's prescription volume.
Quality Manufactured in the USA	All units are assembled under strict ISO standards.	Ensures excellence in performance and durability.
Ease of setup	Counting cell can be calibrated on-site.	Flexibility to modify drugs in the system.
Quality training	Eight-hr. training equips employees to operate machine.	Parata-developed training enables all users, pharmacists and techs, to quickly gain competence and comfort using the machine.

2004 Pharmacy Day in the Legislature

This year's Pharmacy Day in the Legislature brought together 225 pharmacists and state Legislators on June 16 in Raleigh. Participants took this opportunity to talk with their Legislators about important pharmacy issues.

The day kicked off with a Health Fair in the Legislative Building from 9:00 am to 3:00 pm. Pharmacists and students from the University of North Carolina and Campbell University were on site to address medication-related questions and provide one-on-one health awareness screenings in the areas of Cardiovascular Health, Diabetes, Body Composition Analysis, and Osteoporosis.

From 3:15 to 5:15 pm a program was held in the North Carolina Museum of History so participants could learn about current political issues and the basics of influencing elected officials. Later in the evening, pharmacists had the opportunity to meet with Legislators at a reception held from 5:30 to 7:00 pm in the lobby of the Museum.

Pharmacy Day was sponsored by the Association of Community Pharmacists, the Chain Drug Committee of the North Carolina Retail Merchants Association, the North Carolina Association of Pharmacists, and the North Carolina Chapter of American Society of Consultant Pharmacists.

Representative Susan C. Fisher receives an osteoporosis screening.

Representative Bobbie H. Barbee, Sr. has his blood pressure checked by Campbell University pharmacy student Jeanette Yoder, PY-4.

NCAP Launches Drug Importation Safety Campaign

North Carolina was the ninth state to launch the "Looks Can Be Deceiving" public information campaign to assist pharmacists in educating the public about the dangers of drug importation. NCAP and the North Carolina Board of Pharmacy worked with the US Food and Drug Administration to make this campaign successful. On May 26 a press conference was held in Raleigh in the press room of the NC General Assembly. State Rep. Edd Nye called the conference to order and pharmacy leaders including NCAP Executive Director Fred Eckel, NCAP President Mark Gregory and NCBOP Executive Director David Work were on hand to field questions from the press about the dangers of drug importation. The press conference was followed by a media tour of Person Street Pharmacy in Raleigh where owner Mike James was interviewed by local media.

Prior to the media launch, kits containing more than half a million "Looks Can Be Deceiving" bag stuffers, flyers and posters warning of the dangers of drug importation were sent to 575 pharmacies in NC to be displayed and distributed to patients.

Spectrum Science Media of Washington, DC assisted with the launch of the campaign and tracked a combined 1,218,259 successful newspaper and television media "hits." The media launch was covered by dozens of major television stations and newspapers, including the Associated Press.

"Looks Can Be Deceiving" debuted in Illinois pharmacies in February and since then has expanded to Texas, California, New York, Maryland, Virginia, Missouri and Alabama.

During the news conference David Work explained to the media that people who get their medicines from Canada, where government price controls keep prices far below those charged in the United States, might not realize that they can receive fake pills or drugs that have been tampered with. The North Carolina Board of Pharmacy already has obtained temporary injunctions against six businesses that sold cheaper drugs from Canada to North Carolina residents and the Board has filed cease-and-desist orders against six additional pharmacies.

Mark Gregory made it clear that "the safety net is between the doctor, the pharmacist and the patient. Any disruption of the distribution of this product outside the relationship is really a safety issue." ❖

(l to r) Mark Gregory, Fred Eckel and David Work field questions from a room full of reporters representing radio, television and print media.

(l to r) Jean P. Fisher, Staff Writer for the *Raleigh News & Observer*, interviews David Work and Mike James at the May 26 press conference.

Mark your calendar now for the

NCAP Convention

Oct. 25-27, 2004, Sheraton Imperial Center, RTP, NC

Sample Topics

Pharmacist Care: Is it Pointing You to Pharmacy's True North?

Medication Therapy Management Services: Where Are They Going?

Significant Papers:
- Women's Health Initiative
- The "Statins"
- Critical Care
- Technology in Patient Care

Sample of Concurrent Sessions

For Chronic Care Pharmacists:
- *Update on Alzheimer's Disease Treatment*
- *Beer's Criteria – Where Are They Now?*

For Community/Ambulatory Care Pharmacists:
- *Compounding Regulation – Where Is It Going?*
- *Pharmacist Immunization Services in North Carolina*

For Health-System Pharmacists:
- *Technology and Systems – A "Pearls Session!"*
- *Implementing National Patient Safety Goals*

For Preceptors:
- *Evaluating and Grading Students*

For Pharmacy Technicians:
- *Current Pharmacy Laws and Regulations*
- *New Drugs – the Past 12 Months*

For Students and Residents:
- *A Workshop: Pharmacist Care: Is it Pointing You to*
- *Pharmacy's True North?*

Sample Plenary Session

Perspectives from Washington, DC
- Medicare Drug Benefit
- Drug Importation
- Prescription Drug Cards
- Prescription Assistance Programs

Current Guidelines for Treatment
- Heart Failure
- Anticoagulation
- Surgical Prophylaxis
- Myocardial Infarction

Additional quality programming is still in the planning stages. The Convention will also include a Side Syposium, a large exhibit program, a Residency Showcase, and an Awards Ceremony and Reception. Look for an NCAP Convention brochure in your mailbox soon!

NCAP's 2004 Acute Car

More than 450 people attended NCAP's Acute Care Practice Forum meeting April 26-28, 2004 at the Sheraton Hotel at Four Seasons/Koury Convention Center in Greensboro. The meeting attracted pharmacists, technicians, residents and students. There were 24 presentations during the Poster Session on April 27, and 52 vendor booths filled the exhibit hall. Mark your calendar for the NCAP Convention in Raleigh, October 25-27.

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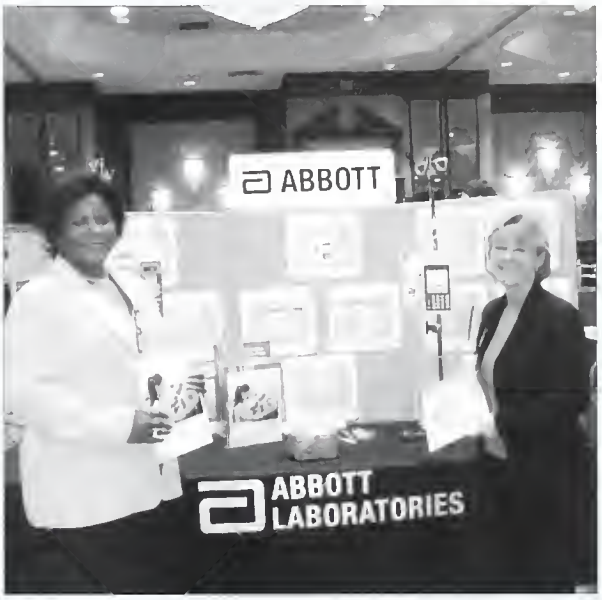

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A Culture of Safety

The Institute of Medicine (IOM) Report, *To Err Is Human*, directed national attention to the problem of medical errors.[1] The report stimulated a critical review of patient safety by consumers and health professionals alike.

by Bob Cisneros

The IOM placed much importance on the "culture" of an organization. Concern for patient safety was urged to be a guiding principle woven into the very fabric of an organization.[1]

Culture & Safety

Lewis et al.[2 (p 355)] defined an organization's culture as the "shared, emotionally charged beliefs, values, and norms that bind people together and help them make sense of the systems within an organization." Workplace culture helps create the "unwritten" rules that often shape important decisions and dictate what is acceptable or unacceptable behavior.

What is a "safety culture?" The Veterans Affairs National Center for Patient Safety (VANCPS) has described a safety culture as a continuous effort by an organization to improve its system, make it safer and to never be satisfied with the status quo.[3] How can an organization's culture influence safety? One need only look at the tragedies that have occurred throughout history for examples.

Consider the sinking of the Titanic.[4,5] At the British inquiry following the tragedy, Captain Maurice Henry Clarke, the naval safety officer who cleared the Titanic for sailing, took the witness stand. The discussion turned to Clarke's approval of the apparently inadequate safety drill held aboard the Titanic immediately before sailing:

"Did you think your system was satisfactory before the Titanic disaster?"

"No, sir."

"Then why did you do it?"

"Because it was the custom."

"Do you follow a custom because it is bad?"

"Well, I am a civil servant sir, and custom guides us a good bit. [5 (p 167)]

Clarke signed off on the Titanic. The naval safety culture of the times prevailed.

Consider the NASA tragedies. Perrow commented on the Challenger explosion and described NASA as "a damaged organization that allowed unique production pressures to override safety concerns." [6 (p 379)] This critique is consistent with the belief of James Reason (an international expert on human error) that when a conflict exists between choices of production or protection, decisions are usually in favor of production until a tragedy occurs.[7]

In the aftermath of the Columbia tragedy, Oberg wrote an MSNBC column entitled "The Hole in NASA's Safety Culture." [8] He criticized the way NASA engineers concluded that no wing damage had occurred to Columbia during launch. Oberg believed that NASA was a victim, again, of the dangerous safety delusion that "in the absence of contrary indicators, it is permissible to assume that a critical system is safe, even if it hasn't been proved so by rigorous testing."[8] Perhaps another way of wording this delusion is: "If nothing bad has happened before, why worry now?"

Types of Cultures

Organizational cultures have been differentiated on the basis of their safety characteristics: pathologic, bureaucratic and generative.[7] Characteristics of a pathologic culture include a passive ("I don't want to know") approach to problems and an atmosphere in which the discovery and reporting of problems is prevented or discouraged. This type of organization tries to stay just one step ahead of a regulatory or accrediting agency (such as a State Board of Pharmacy or JCAHO).[7]

A bureaucratic culture is one in which "spot" repairs are made when system wide changes may be better, new ideas may be regarded as headaches, and safety concerns may not make it through "the system." A generative culture on the other hand proactively seeks safety information, the reporting of errors and safety concerns is valued, failures can lead to system wide changes, and new ideas and approaches are encouraged.[7]

Culture & Medication Errors

The culture of an organization can determine how well errors are detected, reported and prevented.[1,7,9] The traditional medical safety model has been one that was more concerned with fixing blame than improving the system. Leape has referred to this as the "blame and train" approach to medical error. [10] This is unlike the approach used in other industries, such as aviation, in which safety and accident prevention are driving forces in design and procedures. A part of this "aviation safety culture" is an FAA voluntary reporting system in which reports of accidents and near misses are encouraged. Immunity is an important part of this reporting system. [10]

In a culture of safety, improving the system rather than punishment or finding blame is a priority. Most errors are not intentional. According to Reason, it is difficult to correct or control unintentional acts.[7] Focusing on personal blame can lead to the failure to identify inherent weaknesses in a system. In the institutional or community pharmacy setting, this can create a disaster waiting to happen for an unfortunate patient (and pharmacist). Deficient employee training methods, inadequate policies and procedures, excessive workload, etc. are all potential contributors to a dangerous environment that might be overlooked in a rush to assign blame.[7]

The establishment of a learning environment is an important element of a safety culture.[1,3] In this type of environment, reporting of errors and dangerous conditions would be encouraged. Communication would flow freely in all directions, regardless of the lines of authority. There would be no retaliation or penalties for the reporting of errors or unsafe conditions.

According to the VANCPS: "We don't believe people come to work to do

a bad job or make an error, but given the right set of circumstances any of us can make a mistake. We must force ourselves to look past the easy answer that it was someone's fault, to answer the tougher question as to why the error occurred. It is seldom a single reason." [3]

A concern is that a systems focus will excuse individuals from any responsibility for their own mistakes. Will every mistake be considered the result of a bad system with no responsibility for the person who made a mistake, i.e., "the system made me do it?" Such is not the intention of a systems approach to error prevention. In fact, in its own report, the IOM recognized that indeed there are a small number of individuals who may be careless, incompetent and who should be removed from an organization.[1] The report called for organizations to have systems in place to identify these individuals through regular proficiency testing or other certification means, before serious harm is caused.

Reason believes that a complete absence of accountability would lead to an organization that has no credibility in the eyes of its employees.[7] He calls for a just culture in which information regarding errors and near misses can be reported without fear, in an atmosphere of trust. In this culture, the difference between acceptable and unacceptable behavior is clearly drawn by an organization. An atmosphere of fear, retaliation and threats have limited value and can do more harm than good to the workforce. [7]

A true culture of safety is imperative in any type of pharmacy practice. It should be a driving force in the design, development, and provision of pharmaceutical services and systems. An atmosphere in which staff can freely report errors, concerns and near misses is critical in the development of this culture and in the best interest of all patients. ❖

About the Author....

Robert Cisneros, PhD, received his BS in Pharmacy from Northeast Louisiana University (now ULM) and his MS and PhD degrees from Auburn University. His interest in medication safety had its beginnings during his hospital practice in Alabama. He created an elective pharmacy course in medication safety at Campbell University last Fall for P-3 students. He was honored as the P-1 Class 'Professor of the Year' at Campbell University School of Pharmacy in April, 2004, where he is an Assistant Professor. He previously served as Contributing Editor for the ISMP newsletter and continues to work with the ISMP in various activities.

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David Work Receives Fearing Award

David R. Work, Executive Director of the North Carolina Board of Pharmacy was recently presented the M. Keith Fearing Award for lifelong community pharmacy service. The Fearing Award was presented at a special luncheon held in the Pine Burr Room in Marshbanks Cafeteria at Campbell University on Thursday, May 6. The Fearing Award is given in memory of Keith Fearing, a 1941 alumnus of Campbell University who was instrumental in the establishment of the Campbell University School of Pharmacy. Fearing's widow, Lib, was present at the luncheon and assisted with the presentation of the award.

Dr. Jerry Wallace, President of Campbell, greeted the group assembled and expressed appreciation for Keith & Lib Fearing. Wallace said, "When Campbell University made the decision to implement a School of Pharmacy, Keith and Lib Fearing quickly came to our aid and said, 'How can we help?' They gave us invaluable advice and were a constant source of assistance during our process of making the School of Pharmacy a reality."

(l to r) David Work accepts the M. Keith Fearing Award from Lib Fearing and Ron Maddox, Dean of the Campbell University School of Pharmacy.

Work has been the Executive Director of the North Carolina Board of Pharmacy since 1976. Accepting the award, he made reference to the fact that his position is analogous to Dr. Jerry Wallace's ascendance to the presidency of Campbell. Wallace is only the fourth president in the 117-year history of the school and Work is only the fourth executive director of the North Carolina Board of Pharmacy, founded in 1881. Work added that one of his predecessors remained in the position until he was 92.

Work is a tireless consumer advocate, of whom his former pastor, the Reverend Robert Seymour aptly said. "He is appropriately named David (referencing the biblical story of David and the giant Goliath) for his position, by its nature, forces him to be positioned between two giants, the people desiring pharmaceutical products and the producers of the pharmaceutical products. David Work is a responsible citizen who sees himself as a world citizen, an informed voter, and a faithful churchman."

In presenting the award Lib Fearing said, "David, I don't know how you find the time to write for all the publications that you have," now over 150. She referenced a few of the descriptive titles of his publications, such as "We Don't Even Allow Dogs to Die This Way," which appeared in the *Raleigh News & Observer* and was about the drugs used to administer the death penalty to prisoners on death row.

Stan Haywood, president of the North Carolina Board of Pharmacy said, "David Work is a leader who cares about the profession and he has the integrity, honesty, and vision necessary to ably serve in his leadership position."

Work recently received the American Pharmacists Association's (APhA) Hubert H. Humphrey Award. The award, named for the noted pharmacist and former vice president of the United States, was established in 1978 to recognize association members who have made major contributions in government and/or legislative service at the local, state, or national level. The APhA, founded in 1852, is the first established and the largest professional association of pharmacists in the United States, now numbering more than 50,000 members.

In accepting the award, Work said, "At first I was a little embarrassed and then flattered to receive the award. To be honored by your peers and friends is very special and I thank you for the award."

Campbell University School of Pharmacy dean, Dr. Ron Maddox, closed the luncheon by giving a status report on the School of Pharmacy. He thanked those in attendance, a virtual Who's Who in the pharmacy profession in North Carolina and many of whom had assisted in establishing the Campbell University School of Pharmacy. Maddox thanked them for their advice and support and most especially their friendship over the years.

A Campbell alumnus who was a founding member of Campbell University's School of Pharmacy, M. Keith Fearing established the first pharmacy in Dare County. The Fearing Award was established in 1997 to honor his memory and the contributions he made to pharmacy. ❖

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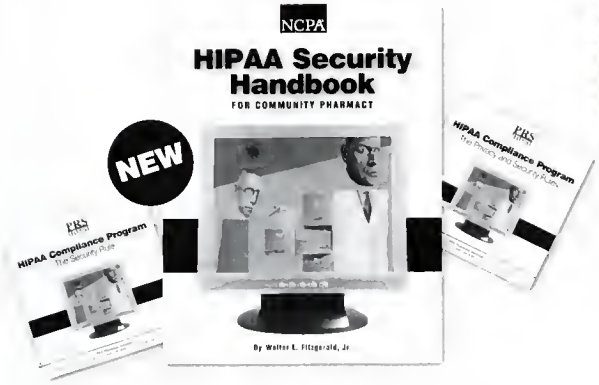
HIPAA security rule **deadline**



April 20, 2005, the Security Rule portion of HIPAA becomes law. Unlike the Privacy Rule, which became enforceable April 14, 2003, the Security Rule takes place behind the scenes and regulates your pharmacy operations, computer systems, and electronic information. The Security Rule is predicted to require more time to implement than the Privacy Rule, so don't delay. A Risk Analysis and a Disaster Recovery Plan are mandated under the Security Rule—**Are you ready?**

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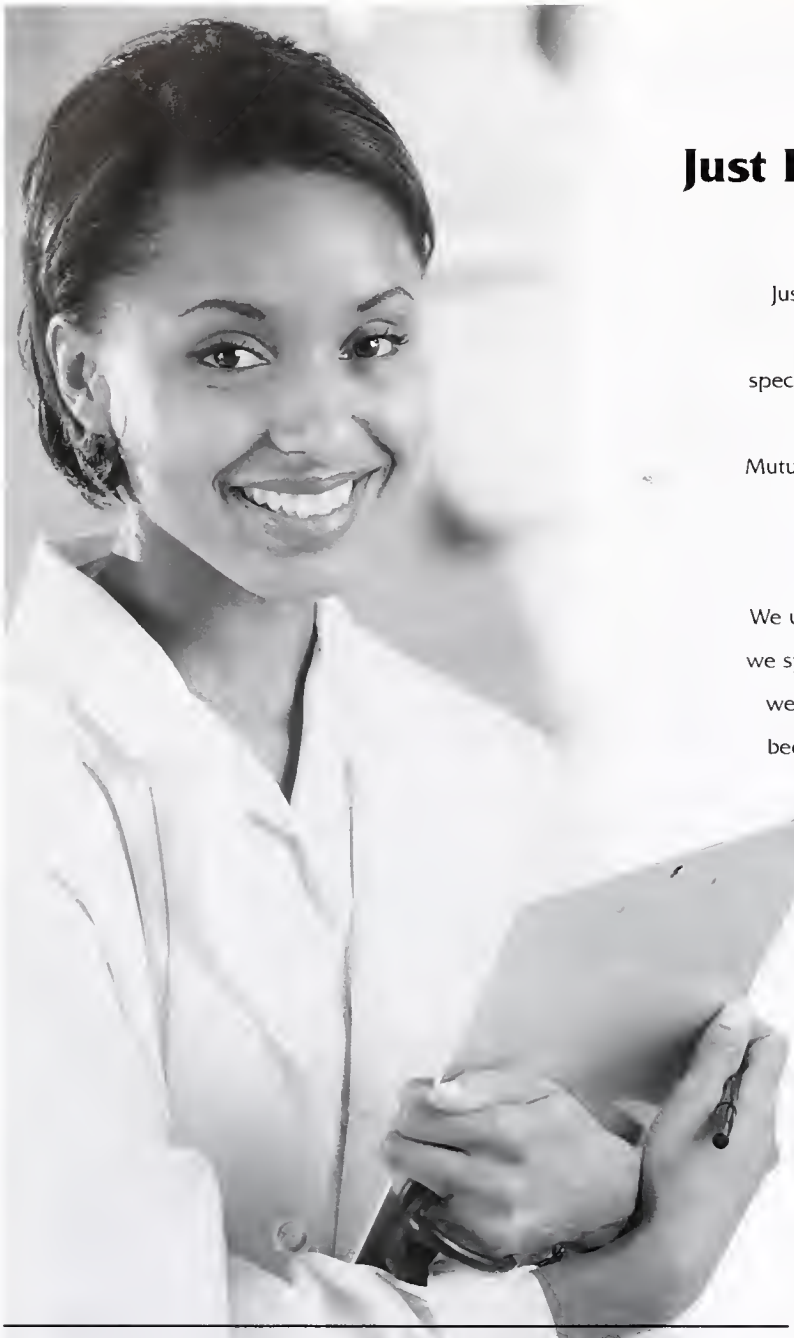

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Carolina Regional Conference

The 2004 Carolina Regional Conference for Senior Care Pharmacists was held March 25-26 at the Hilton at University Place in Charlotte. The meeting also served as NCAP's Chronic Care Practice Forum Meeting.

(top, l to r) NCASP officers: Educational Affairs Chair Lori Edwards, Organizational Affairs Chair Margaret Sgritta, Secretary/Treasure David Schomberg, and President-elect Cecil Davis who is also the Chair of NCAP's Chronic Care Practice Forum.
NCASP officers not pictured:
Penny Shelton, President
Susan Hoy, Membership Affairs Chair
Holly Nunn, (bottom photo)Student Membership Affairs Co-Chair
Ann Marie Nye, Student Membership Affairs Co-Chair
Charles Watson, Government Affairs Chair
(bottom, l to r) Rebekah Roufe, Holly Nunn and Otowve Eduvie. Rebekah and Otowve, students at Campbell University School of Pharmacy, assisted with meeting registration, packets, handouts and exhibits.

Provisional Staffing Cures for Today's Pharmacies

Sooner or later, every pharmacy faces the challenge of juggling staff schedules around vacations, illness, training and education courses. Often it is possible to plan around these absences, but emergency situations will inevitably arise. Finding an available pharmacist or experienced technician can be a worrisome headache. Many pharmacies have come to rely on temporary agencies to help maintain adequate staffing.

Of course, every agency should be able to provide references from pharmacies with which they have successfully used the agency's services, but there are several factors to consider when hiring a temporary placement agency.

1. Does the agency specialize in referring pharmacists and technicians?

Agencies who specialize in one specific field will likely have a better understanding of your necessities and be able to "speak your lingo."

2. Is the agency pharmacist-owned or is there at least a pharmacist advisor on staff?

This can make a big difference in the agency's ability to understand your staffing needs and be able to match qualified candidates who have the correct experience directly related to your pharmacy setting.

3. How carefully does the agency screen personnel?

An agency should select their Pharmacists and Technicians carefully, taking certain steps to ensure proper exactness when choosing a qualified individual. The following are some steps that should be followed when performing proper credentials checks: a) A formal registration procedure, b) Review of work history and experience, c) Reference checks, d) Checking to make sure the pharmacist's license is in good standing, e) Verifying liability coverage.

4. Does the agency have state of the art computer matching and scheduling capabilities?

In an emergency situation, quick response is vital. Operating "the old fashioned way" may slow down the agency's response time in locating available personnel. Computer capabilities can make it possible to fill a vacancy within minutes. Relying on a manual system may take hours simply to locate all available personnel, and even longer to find someone with the requisite qualifications needed to fill the position.

5. Does the agency have personnel available in your local area or close by?

Finding someone in your area or close by is essential. You may ask yourself whether or not you will incur travel costs for mileage if their personnel came from a distance. This generally will not be a problem if occurring occasionally, but can add up to significant costs for frequent placements. Some Pharmacists are located in fringe areas and may expect to be compensated for mileage. On the other hand, there are some agencies that do not charge for mileage no matter where the location.

6. Does the agency have personnel with experience in your type of pharmacy?

Duties and customer/patient interaction can vary significantly from one pharmacy setting to another. If your pharmacists are in a home-health care setting and the agency's personnel only has retail experience (or vice-versa), an experienced person may not be available. It is crucial to maintain an experienced person in an environment of which they have prior knowledge.

7. Can the agency be reached at any time?

Your pharmacy may be open late at night or around the clock. Emergency situations, sick calls and sudden realizations about scheduling gaps can come at any time, even the middle of the night. Knowing you can place a request at any time can provide much needed peace of mind.

8. Does the agency have the ability to refer personnel in permanent positions?

While not a requirement for temporary staffing, should the need arise for permanent staff, an existing relationship with a temporary agency that also places permanent positions means you will be dealing with an agency you know and trust.

9. Are pharmacists placed by the agency covered by professional liability insurance?

Whether the Pharmacists being referred are employees of the agency or an independent contractor, he or she should be covered by adequate professional liability insurance.

10. Is the staffing agency communicating with you in all possible areas?

With today's technology there are many ways to communicate without disruption to your daily responsibilities. By utilizing updated modes of communication you will enhance your ability to get your correspondence across in a timely manner. ❖

By Robert Miller, RPh,CPh, President, Healthcare Consultants Pharmacy Staffing

TRAVEL OPPORTUNITIES

NCAP is sponsoring the following trips in 2005 for members, their families and friends in cooperation with Collette Vacations:

***The Call of the Canyon*, Phoenix-Sedona, AZ, 3/13/05, 6 days**

***Canadian Rockies by Rail*, 6/14/05, 9 days**

***Reflections of Italy*, 9/12/05, 10 days**

Call Linda Goswick at NCAP for a brochure and more details: 919-967-2237or e-mail linda@ncpharmacists.org

NCAP Scholarship Winners

Jana Allessi, PharmD Class of 2005 and past President of Campbell University's APhA Academy of Students of Pharmacy, was awarded the NCAP Student Member Scholarship Award at the school's annual Parent's Day program April 3. The Award recognizes Jana's superb leadership of the Campbell University Student Chapter as well as her excellent academic qualifications. (l to r) Award recipient Jana Allessi, NCAP Past President Jack Watts, and Campbell University Associate Dean Tom Holmes.

Jennifer Weissert from Wingate University School of Pharmacy was awarded the NCAP Student Member Scholarship for 2003-2004. Weissert was recently elected as President of Wingate's new unified student professional organization, PILLS (Pharmacy Learning, Leadership, and Service). With her fellow officers, she has developed bylaws for the organization, appointed liaisons to each organization and created four committees: professionalism, service, public relations and membership. Weissert also organized Wingate student participation in the Student Leadership Workshop sponsored by NCAP.

NCAP Sponsors White Coat Ceremony for UNC Students

The North Carolina Association of Pharmacists and the Pharmacy Foundation of North Carolina sponsored a White Coat Ceremony for the UNC School of Pharmacy Class of 2005 on April 2. Davie Waggett, President-Elect of NCAP and a 1978 graduate of UNC, delivered a message to students and faculty on behalf of NCAP. Pictured above are some rising PY-4 students modeling their new white coats: (l to r) Anna Riddle, Billy Soffera, Sue Vacek, Jeremy Smart, Will Austin, Amy Fussell Hollar, Ali Hartigan, and Amanda Whitehead.

2004 Calendar

September 10-12: ***Pharmacy Practice Seminar (Ambulatory Care Practice Forum Meeting) & Pharmacy-Based Immunization Delivery Program.*** Wilmington Hilton, Wilmington, NC. Register online at www.pharmacy.unc.edu/continuing/onlinereg. For more information e-mail Sherrie Moore at sherrie_moore@unc.edu or call the CE office at 919-966-1128.

October 25-27: ***NCAP Annual Convention,*** Sheraton Imperial, Research Triangle Park, NC. Quality CE, outstanding speakers, networking opportunities and more. Look for a brochure in your mailbox soon or call NCAP at 919-967-2237 for more information.

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However, our building is in need of repair and refurbishing right now so the Pharmacy Network Foundation has provided another challenge to NCAP members. They have pledged to match contributions to the Building Remodeling Fund on a two-to-one basis, up to a total contribution of $50,00 per year over two years. If we meet their challenge we'll have $150,000 to refurbish and repair our building now.

Past President Jack Watts continues to chair this fundraising effort. Your contributions are tax-deductible so please say *"Yes I can help preserve the Institute of Phammacy."*

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North Carolina Pharmacist

Volume 84, Number 4 ...applying drug knowledge to improve health Fall, 2004

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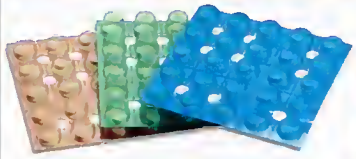

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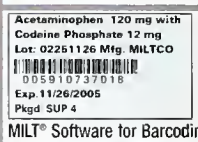

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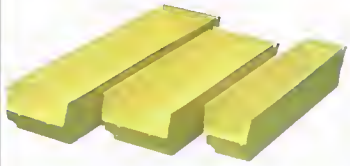

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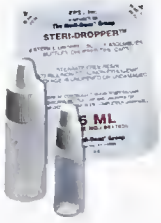

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North Carolina Pharmacist

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Inside

Special Continuing Education Supplement

In order to better serve our members, NCAP will mail a special CE Supplement only to members who request it. If you would like to be added to the mailing list for CE contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 22.


President Mark Gregory

Leading Change

Dear NCAP Members,

For over eighty years pharmacists and physicians, with the assistance of regulatory agencies, have put together a system for the prescribing, dispensing and use of prescription medications in the United States. Because of this system we can be assured that the medicine we take is safe and effective when prescribed and taken appropriately.

This system has made available to us the most innovative, safe and effective medicines in the world.

Over the past five years, pharmacy fragmentation has occurred as a result of a narrow focus on cost rather than the related benefits in medication use provided by our system. As a result, our safe and effective controls have been compromised. Correct medication therapy decisions are sometimes based solely on the latest television commercial; what the three tiered co-pay dictates; or which medications can be supersized to a ninety-day supply through a mail order facility. Further complicated by the many channels of drug distribution including; across the border; in the mailbox; over the internet; via the sampling cabinet; prescribed from many different healthcare practitioners; and possibly from many different community pharmacies, continuity of care is virtually impossible and potential drug interactions between medications go undetected.

As we head into the 21st century, our drug distribution system is flawed. Our system now places the patient in a position of healthcare jeopardy. Price is not the primary issue. The primary issue is for us to refocus on safe and effective drug products and appropriate prescribing, dispensing, and use of medications.

The pharmacist is perfectly positioned to bring the system back to goal. While there are small examples where pharmacists have developed this model with self-insured employers, in pilot programs, or with some of our State agencies, the opportunity grows to a much larger scale with changes to the Medicare Modernization Act (MMA) of 2003. With Medicare Part D, the opportunity now exists to change the pharmacy paradigm through legislation that mandates regional Part D providers to include Medication Therapy Management (MTM) as part of the benefit.

If properly implemented, this legislation will provide:

- unprecedented national recognition of the pharmacist as a healthcare provider;
- better care for patients and reduced total health care expenditures;
- a new stream of pharmacy service revenue;
- improved pharmacist job satisfaction; and improved customer/patient satisfaction.

The consensus pharmacy definition of MTM services is to optimize therapeutic or clinical outcomes, with the services occurring coincident to the dispensing of a prescription, or independent of that process.

In North Carolina, we should be excited to know that CMS has engaged pharmacy practitioners in our State to assist in the development of MTM protocols. With many pharmacies in the Washington, DC area at their disposal, Senior officials of CMS instead visited community pharmacies here to learn about MTM delivery.

To reach the goal described above, we need to ensure that MTM programs are :

- Delivered by the pharmacist;
- Tailored to the needs of the individual patient;
- Characterized by FACE-TO-FACE patient/pharmacist interaction; and
- Structured to provide FAIR payment for pharmacist services based on resources utilized.

The magnitude of the opportunity for pharmacy presented by the MMA should not be underestimated. This is the first time in our history that the pharmacist has been recognized as a healthcare provider in federal legislation. That, in itself, is huge.

What do we need to do?

A few suggestions....

We must first accept the fact that SIGNIFICANT CHANGE IS NECESSARY, and second, develop effective action plans for successful execution.

We must evolve our current thinking from a mindset of customer service to strategies regarding patient care. We must expand our view of the customer, as not only a customer, but a patient. Customers are consumers of products. Patients may also be consumers of products, but they are also consumers of healthcare services.

We will change the face of practice by better applying the tremendous knowledge and skill of our nation's community pharmacists to meet the needs of patients. By redefining the pharmacist-patient relationship, we will have better access and better communication between the pharmacist, patient, and primary care provider, thereby yielding better clinical outcomes and ultimately improving patient quality of life. These positive clinical outcomes will translate into greater patient satisfaction and improved humanistic outcomes and positive economic outcomes. This is not a hypothesis, results have been documented, peer-reviewed, and published. Pharmacist-provided care in the management of chronic disease results in better compliance, fewer hospitalizations, ER visits, workplace absenteeism, thereby producing a significant net reduction in total healthcare costs.

In order to realize the great potential offered by the MMA, there is no doubt that we must present a unified front to enable our profession to rise to the challenge of leading change for the future of healthcare.

We must put the walk to the talk, meaning we must provide the quality, and then accept nothing less than fair compensation for our services in return. If you only take one thing away from this column, let it be that the time for empty rhetoric has passed!

NCAP will be active and we need you to be active! The opportunity is ours...let's lead the change!

Mark Gregory, RPh
President
NCAP

NCAP Celebrates Five Years of Leading Pharmacy Into the Future.

We work for *all* pharmacists but only *some* pharmacists contribute.

Are you coming with us?

Dear Pharmacists,

Since I became Executive Director of NCAP, I often hear the questions: "What does NCAP do for me," or "Why should I join NCAP?" The implications of these questions being asked by a prospective member is "How can I justify paying the dues?" This is often a difficult question to answer because NCAP has different advantages and benefits for different pharmacists. Frequently, employee pharmacists feel like their employer is meeting all of their needs so they ask "What have pharmacy associations done for employee pharmacists?"

Perhaps a better question for all pharmacists to ask is "What have pharmacy associations/NCAP NOT done?"

NCAP is working for all pharmacists.... consultant pharmacists, independent pharmacists, chain pharmacist employees, health-system pharmacists, and for pharmacy students and faculty members. I have encountered many pharmacists who are only interested in protecting or advancing their own area of pharmacy practice. ***NCAP believes that if any pharmacy practice area hurts, all pharmacists suffer.***

Pharmacy needs an organization that focuses on the needs of the entire profession but can still collaborate with the professions specialty groups as necessary. As you review the activities and accomplishments of NCAP in its first five years, I hope you will agree with me that those who made the decision to create NCAP were right. North Carolina pharmacy is better off today because of that decision. Just think how much more we could accomplish if every pharmacist joined with us.

Remember, NCAP supports ALL pharmacists but many pharmacists have not been willing to pay for their share of that support. All pharmacists need a strong NCAP and NCAP needs the financial support of all pharmacists.

Sincerely,

Fred M. Eckel
Executive Director

NCAP: Who We Are and What We Do

Mission Statement

The North Carolina Association of Pharmacists is the state organization representing the profession of pharmacy, organized to unite, serve and advance the profession of pharmacy for the benefit of society. The organization was formed January 1, 2000 as a unification of the North Carolina Pharmaceutical Association (NCPhA), North Carolina Society of Health-System Pharmacists (NCSHP), North Carolina Chapter of the American Society of Consultant Pharmacists (NCASCP), and North Carolina Retail Pharmacy Association (NCRPA).

The objectives are:

- To present a unified voice for pharmacy on social, political and financial issues.
- To provide a forum for exchange of innovative ideas among pharmacists and collaborate with other health care providers to establish progressive health systems.
- To promote the optimization of drug therapy for the people our members serve.
- To anticipate future information and professional development needs for pharmacy practice.
- To strengthen relationships among pharmacy students, pharmacy practitioners and other health professionals.

As we complete five years of operation it is time to celebrate our accomplishments, evaluate the organization, and make course corrections as appropriate.

Addressing Political Issues

Lobbying

NCAP employs Zeb Alley, rated as one of the most effective lobbyists in Raleigh, to monitor pharmacy issues. When the Legislature is in session he provides weekly updates which are posted in the Legal & Public Affairs area of the NCAP Web site.

Pharmacy Day in the Legislature

Each year NCAP makes sure pharmacy's message is delivered directly to our Legislators in Raleigh. Pharmacy Day in the Legis-

lature gives members a chance to meet and interact face-to-face with their elected officials. Pharmacists make afternoon appointments with their Legislators while students and pharmacy school representatives hold a health fair in the Legislative Building to address medication-related questions and provide health awareness screenings. At an evening reception, Legislators and pharmacists meet once again to discuss pharmacy issues.

Clinical Pharmacist Practitioner Act

NCAP was instrumental in forming a collaboration between pharmacists and physicians in North Carolina that allows patients a new way to access healthcare and improve drug therapy outcomes. Pharmacy leaders met with the North Carolina Medical Board in 1999 to develop regulations for the Clinical Pharmacist Practitioner Act. The Act became effective July 1, 2000. Clinical Pharmacist Practitioners (CPP's) are approved by both the Boards of Pharmacy and Medicine. A CPP is defined as a "licensed pharmacist in good standing who is approved to provide drug therapy management under the direction of, or under the supervision of, a licensed physician who has provided written instructions for a patient and disease specific drug therapy which may include ordering, changing, substituting therapies or ordering tests." A special section for CPP's can be found on the NCAP Web site at www.ncpharmacists.org.

NCAP is housed at the Institute of Pharmacy in the heart of Chapel Hill.

Medicare Clinical Pharmacist Practitioner Services Coverage Act of 2004

NCAP is currently capturing national attention with the introduction of a bill to recognize Clinical Pharmacist Practitioners as providers under Medicare Part B. The bill is HR4724, the "Medicare Clinical Pharmacist Practitioner Services Coverage Act of 2004." As of press time it is still possible for the bill to move forward as an attachment to the Omnibus Budget Bill when Congress reconvenes.

Pharmacy Technician Bill

NCAP is committed to the professionalization of the pharmacy technician and was instrumental in passing legislation to define technicians and require registration with the Board of Pharmacy. Ultimately, a well-trained technician will enhance the role of pharmacists, allowing them to attend to other professional duties such as patient counseling and drug therapy management.

In the year 2000, NCAP's Technician Task Force began developing language for the Pharmacist Technician Bill. On August 17, 2001 legislation was signed recognizing the entity of pharmacy technicians. This law provides a way to track pharmacy technicians by requiring registration with the North Carolina Board of Pharmacy. It also includes guidelines on minimum training requirements for technicians and it allows for the expansion of the 2:1 technician to pharmacist ratio, provided the additional technicians have passed a nationally recognized certification board exam and the Board of Pharmacy has provided written approval. Technicians are now also included in the Pharmacist Recovery Network. Keys to passing this bill included the attendance of pharmacists and technicians at Pharmacy Day in the Legislature and working closely with our lobbying firm, Zeb Alley and Associates.

NC Medicaid Program

In the Winter, 2002 issue of *North Carolina Pharmacist*, NCAP questioned North Carolina's Medicaid Program Leaders about the reduction in pharmacists' dispensing fees, how pharmacy should fit into the healthcare system, and the role of government in addressing the pharmacy needs of citizens. Participants in the Q&A included Senate Majority Leader Tony Rand, Speaker Jim Black, DHHS Secretary Carmen Hooker Odom, and the Pharmacy Program Manager from the Division of Medical Assistance, Sharman Leinwand. They all recognized the important role pharmacists play. To be sure pharmacists continue playing a role, NCAP's lobbyist works closely with the North Carolina Pharmacy Lobbying Coalition to monitor what is happening with Medicaid, offer solutions to problems being addressed, and work with the Legislature to assure fair treatment of community pharmacists.

Medicare Rx Drug Discount Card

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 created much confusion for not only patients, but pharmacists as well. The Spring, 2004 issue of *North Carolina Pharmacist* provided readers with easy-to-understand information about how the new Prescription Drug Discount Card Program works. Insights from community, chain, and long-term care pharmacy leaders, as well as from the Deputy Commissioner of North Carolina's Department of Insurance, were included. NCAP will continue to monitor the implementation of the Act and alert and educate members about each provision of the law as it goes into effect.

Drug Importation

North Carolina was the ninth state to launch the "Looks Can Be Deceiving" public information campaign to assist pharmacists in

educating the public about the dangers of drug importation. NCAP and the North Carolina Board of Pharmacy worked with the US Food and Drug Administration to make this campaign successful. In May of 2004, a media launch was held in the press room of the North Carolina General Assembly. State Rep. Edd Nye and NCAP pharmacy leaders were on hand to field questions from reporters. The press conference was followed by a media tour of Person Street Pharmacy in Raleigh. Prior to the media launch, kits containing more than half a million "Looks Can Be Deceiving" bag stuffers, flyers and posters, warning of the dangers of drug importation, were sent to 575 pharmacies across the state to be displayed and distributed to patients. The media launch was covered by dozens of major television stations and newspapers and the campaign received over 1.2 million successful newspaper and television "media hits."

Assisting the Board of Pharmacy

Since the Board of Pharmacy cannot sponsor legislation, at NCAP's request, legislation was introduced. This allowed the Board to purchase land for office space rather than incurring ongoing rent as a tenant.

Professional Assistance and Advancement

The Asheville Project

Pharmacists in North Carolina have made a tremendous difference in the health and lives of patients though the development of the Asheville Project, now a well-know national model for pharmacists' care of patients with chronic disease.

In 1996 the pilot program was developed and diabetic employees of the City of Asheville were paired with local pharmacists who coached and monitored the workers through a regimen of diet, exercise and medication. Mission St. Joseph's Hospital covered the cost of education programs not normally covered by city insurance programs. The result: 90 percent of the study group demonstrated significant improvement in blood sugar levels, employee sick days were cut in half and the city saved $25,000 in health care costs. Participants reported feeling healthier and happier. A win-win situation for all.

The purposes of this project was to develop practical working pharmaceutical care models and demonstrate the value of utilizing community pharmacists to provide pharmaceutical care services in improving patient care. If the project could successfully develop practice models that measurably improved patient outcomes, the model could then be expanded and the data used to lobby for payment from a variety of payers.

The Asheville Project has demonstrated that there are payers who are willing to pay pharmacists to provide these services. This is because it has also demonstrated that pharmaceutical care services do make measurable clinical and financial differences.

The City of Asheville was so pleased with the program's results, they asked pharmacists to provide a similar service for their employees who have asthma, hypertension and/or hyperlipidemia. Today over 800 patients are being followed by pharmacists, four different employers participate, and the financial and clinical benefits continue.

Diabetes Community Health Project Toolkit

The successful Asheville Diabetes Project resulted in the opportunity to assist pharmacists in other communities to implement a diabetes management program. A Diabetes Toolkit was developed to provide pharmacists with all the information, forms, letters and resources needed to implement a Diabetes Project in a local pharmacy. The toolkit has been distributed throughout the country. More than twenty programs have been implemented based on the Asheville Project model.

Public Relations Toolkit

During a Leadership Development conference in 2001, NCAP introduced the "NCAP Public Relations Toolkit," designed to help pharmacists improve patient and community relations. The kit provided tools to help members carry out NCAP's Annual Implementation Plan of 2001, "Communicating the Value of the Pharmacist and the Role of the Pharmacy Technician to the Public." The PR Toolkit included a patient flyer with answers to commonly asked questions about the role of pharmacists and technicians, tips on medication and safety, and information on health benefit plans. There were also tips for working with the media, guidelines and samples for writing letters to the editor, and a list of North Carolina media contacts to help pharmacists get their message to the right person.

Workplace Issues Task Force

NCAP has worked with the North Carolina Board of Pharmacy to address the concerns that pharmacists have expressed about working conditions in some practice settings. The recommendations arising from this have provided direction to NCAP as the association works with large employers to improve the working conditions of pharmacists.

www.ncpharmacists.org

The NCAP Web site has been noted as one of the leading association Web sites in the southeast. Members can access a wealth of information, stay current on North Carolina pharmacy issues, network with other members, and that's just the beginning! There is a Legal and Public Affairs section containing legislative updates and government contacts, and an Education and Training section with CE Schedules, online CE, and a Residency listing. The ever-popular Web Classifieds help those seeking employment, or those seeking employees. An extensive Links Section serves as a portal to the internet connecting members to a multitude of resources including medication information, clinical research and drug trials, education and library services, government sites, manufacturers, and local, state and national associations. There is also a Meeting and Events section, Current News, and a special section for Clinical Pharmacist Practitioners. It's truly a wellspring of information.

Understanding Automation

Many pharmacies are putting robotic dispensing technology to work for a variety of reasons, including increased prescription processing speed which results in more time to perform other duties including patient counseling. The last issue of *North Carolina Pharmacist* featured practice sites of members who are using this tech-

nology and examined a North Carolina based company that manufactures robotic dispensing systems.

Providing Valuable Education

NCAP Annual Meetings

Outstanding speakers, quality CE and networking opportunities are available at several NCAP sponsored meetings each year such as the:

- NCAP Acute Care Practice Forum Meeting
- NCAP Annual Convention
- Annual Pharmacy Practice Seminar
- Update on NC Pharmacy Regional Meetings
- NC Pharmacy Residents Conference
- Student Pharmacist Leadership Forum

Technician Certification Exam Review Course

Three times each year NCAP offers review courses throughout the state to help technicians prepare for the Pharmacy Technician Certification Board Exam. The one-day review course also provides seven hours of live CE for technicians who are already certified. In addition, the course meets the Board of Pharmacy formal training requirements for all technicians. This is part of NCAP's commitment to the professionalization of the pharmacy technician.

Assistance with HIPAA

The Association will continue to help navigate members through the "HIPAA Maze." Part of this effort has included the development of a web-based program to assist pharmacists in training, policy-writing and security assessments. NCAP also offers manuals for those who wish to do the work themselves. HIPAA assistance materials are available on the NCAP Web site.

Senior Care Program

The Winter 2003 issue of *North Carolina Pharmacist* offered an overview of the North Carolina Senior Care program. Lieutenant Governor Beverly E. Perdue, along with pharmacy representatives from all practice settings, offered opinions and advice about this vital program that covers approximately 100,000 Seniors. Senior Care has evolved into an excellent program with adequate reimbursement for pharmacists' services.

Drug Diversion

The illegal diversion of prescription drugs is a growing problem. Articles providing information and advice, written by state and federal officials and administrators from the North Carolina Pharmacist Recovery Network, have appeared in the NCAP journal and on the NCAP Web site. The Association intends to keep members informed about how to combat drug diversion.

Bioterrorism Preparedness

Pharmacists, like many others, must be prepared to provide pharmaceutical services and maintain an effective supply of medications to the public despite any disaster, be it natural or terror related. Therefore, an issue of *North Carolina Pharmacist* was dedicated to the subject of bioterrorism. The Strategic Stockpile Manager for the State of North Carolina and a disaster response expert from the US Public Health Service were among contributors that provided crucial information and advice about emergency preparedness.

Medication Errors and Safety Solutions

Each issue of *North Carolina Pharmacist* includes a column written by medication safety experts. This important information keeps members well informed so they can better serve and protect their patients.

Partnerships to Promote Good Health

NCAP has partnered with many organizations such as the North Carolina Heart Disease and Stroke Prevention Task Force, the North Carolina Tobacco Prevention and Control Branch, the Medical Review of North Carolina, the Folic Acid Council and the North Carolina Collaboration on Diabetic Eye Disease to help educate the public on a variety of health issues and promote healthy lifestyles.

Creating a Brighter Future for Pharmacy Students

Staying in Touch with Pharmacy Schools

Each issue of *North Carolina Pharmacist* includes campus activities from Campbell University School of Pharmacy, UNC-CH School of Pharmacy, and Wingate University School of Pharmacy. Just last year a cover story in the association's journal provided a complete overview of each pharmacy school. In 2004, NCAP initiated a Student Pharmacist Leadership Forum for newly elected student leaders. The success of this program suggests it will be an annual event.

Residents Leadership Conference

Pharmacy residents, residency directors, and prominent pharmacy leaders from around the state gather each summer at NCAP's Annual Residents Leadership Conference. The conference gives residents an opportunity to learn about leadership skills firsthand and prepare to become future leaders.

Campus Board Meetings

Part of NCAP's student outreach includes holding a Board of Directors meeting once a year on each of the three pharmacy school campuses. This gives students a chance to meet association leaders and learn more about the structure of NCAP.

Student Pharmacist Loans

NCAP offers pharmacy students with financial needs the opportunity to borrow money that does not need to be repaid until they graduate. Last year 63 loans were made to students from all three schools of pharmacy.

State of NCAP

Finances

In 2001 NCAP finances were in trouble. In fact, for a number of

years the North Carolina Pharmaceutical Association had experienced financial difficulty. The merger brought an infusion of dollars from NCSHP which allowed for a balanced budget during the first year of the new organization. The picture changed in 2001. The Executive Committee decided to outsource some functions, allowing the reduction of one and a half staff positions. Fred Eckel accepted the Executive Director position at a reduced salary. Today, NCAP's finances have recovered. NCAP should finish 2004 with an excess income over expenses of about $75,000. This means we will have about $250,000 in cash reserves as we close out 2004. Fred Eckel has agreed to continue to serve as Executive Director for four years, until 2008. His goal is to leave the association with cash reserves of over $500,000, an Endowment Fund that tops $600,000, and sufficient annual income to support a full-time Executive Director at a competitive salary. These goals are very realistic. North Carolina will once more be recognized as a great place to practice pharmacy because it is supported by a strong state pharmacy association.

Building Endowment Fund

NCAP is housed in The Institute of Pharmacy building in Chapel Hill. The building was constructed in 1950. Throughout the years maintenance was often deferred because of financial constraints. In 2003 a fund-raising campaign was launched to secure the necessary resources to preserve the building. So far $200,000 has been raised. The NCAP Board of Directors agreed to transfer ownership of the Institute to the NCAP Endowment Fund. This will allow the NCAP Board to focus on meeting the needs of pharmacists. The NCAP Endowment Board appointed a Building Management Committee to oversee the repairs and modernization of the building.

Benefits of NCAP Membership

Educational Programming:

- Contact and Correspondence CE Programming.
- Discounted rates at annual meetings.
- Practice Forums that meet the special needs of individual practice settings: Acute Care, Ambulatory Care, Chronic Care and Technicians.
- CE tracking for license renewal.
- Financial support to the North Carolina Center for Pharmaceutical Care and the Continuing Pharmaceutical Education Review Panel.

Legal & Public Affairs:

- Legislative monitoring.
- Coordination of pharmacy lobbying activities.
- Grassroots political activities such as Pharmacy Day in the Legislature.
- Host Forums for discussion of vital issues.
- Promote adequate reimbursement for drug dispensing.
- Promote reimbursement for cognitive services.
- Assure compliance with Uniform Prescription Drug ID card.
- Promote the role of Clinical Pharmacist Practitioners.
- Encourage development of a pharmacist provider network.
- Address workplace issues.
- Expansion of technician role.

Communication:

- *North Carolina Pharmacist*, a quarterly journal that examines current pharmacy issues and trends.
- E-News/broadcast fax to inform members instantly of breaking news events related to pharmacy.
- Web site containing news, an on-line membership directory, and a wealth of information.

Professional Benefits:

- Innovative practice tools.
- Staff expertise.
- Insurance programs to support pharmacists.

What the Future Holds

As NCAP completes five years of progress, the association will be working to improve some operational issues. The policy-making process of NCAP was based on a House of Delegates model. The membership of the House was to come from local associations affiliated with NCAP. This process has not worked well so NCAP leadership will determine the best way to approve policies.

The policy development process, likewise, needs to be evaluated. The pharmacist shortage coupled with busy lives means pharmacists have less time to volunteer, and employers are less able to support employees participating in organizational activities. This has effected how NCAP councils and committees function.

NCAP's efforts to meet the needs of various practice segments, through practice forums, needs to be examined. Some forums have struggled to remain organized. Practice forums and the role they play needs to be addressed.

Recently the American Society for Health-System Pharmacists raised questions about how they want to relate to state affiliates. NCAP needs to address how the association wants to affiliate with national organizations.

At its Strategic Direction Conference, NCAP leadership will address some of these issues. Incoming President Davie Waggett will appoint a committee to provide NCAP with recommendations on how to proceed.

Please contact NCAP if you are interested in being part of this process. ❖

Are you coming with us?

There's more information about NCAP at www.ncpharmacists.org

A membership application can be found on page 23.

NCAP's 2004 Annual Convention

More than 600 pharmacy professionals gathered for NCAP's Annual Convention Oct. 25-27, 2004 at the Sheraton Imperial Hotel in RTP, NC. Seventeen residency programs participated in the Showcase on Oct. 26, and 65 vendor booths filled the exhibit hall. Brian Buford of Waxhaw, NC won a free 2005 NCAP membership by participating in the "Reach One for NCAP" challenge (see page 23 for details). Congratulations Brian! NCAP would like to recognize the following sponsors and contributors who helped make our convention a great success!

"Thank You" to our Sponsors

These companies have provided generous support for our 2004 continuing education programs.

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Purdue Pharma
QS/1 Data Systems
Sanofi-Aventis
Schering Plough
Scientific Retail Systems
Scios
SecondStory Health, LLC
Smith Drug Company
Swisslog
Takeda Pharmaceuticals, North America
The Kroger Company
US Army Healthcare Recruiting
VIP Software

Outstanding NC Pharmacists Recognized at NCAP Convention

The Fifty Plus Club honors members who have served as a licensed pharmacist for fifty years. The 2004 inductees include Willard Grover Creech, George Wesley Harris, Walter Wilcox Howle, Benjamin Kater Mobley, and Sybil Austin Skakle. Not pictured: Herman Sutton Barbrey, David Astor Dowdy, Jr., Lewis Mouchet Ferguson, Calvin Moore Floyd, Jr., Jeremiah Thomas Gaylord, David Thomas Hix, Barbara Dillard Meschke, Paul Owenby, Jr., James Ambler Speight, Joseph Graham White, and Kenneth L. Wiggins.

Christie Hughes receives the Pharmacists Mutual Companies Distinguished Young Pharmacist Award from company representative Ron Stoll.

Bryan Bray receives the Don Blanton Award from Charles D. Blanton, Jr. for his contribution to the advancement of pharmacy in North Carolina.

Fred Eckel presents the Elan Biopharmaceuticals Innovative Pharmacy Practice Award to Randal Von Seggern.

Mark Gregory receives the Merck Pharmacy Leadership Award from Ken Tuell.

Jack Watts presents the NCAP President's Award to 2004 President Mark Gregory.

Rick Bowman of Wyeth Pharmaceuticals presents the Bowl of Hygiea Award to Stan Haywood.

Make plans to attend the NCAP Acute Care Pr

Several outstanding pharmacy leaders were honored throughout NCAP's 2004 Annual Convention. A Tuesday night Awards Banquet featured guest speaker Lee Ragsdale of Wingate University who enlightened the audience with his humor and outlook on pharmacy. Music was provided by singer/songwriter Karl Ruch, a UNC pharmacy student. Those attending enjoyed a fabulous dinner buffet, door prizes and more. The evening ended with the installation of NCAP's 2005 officers who were present. Sworn in were Davie Waggett who will serve as President, and David Smith who will serve as a Board member and Speaker of the House of Delegates.

John Jay presents the McKesson Leadership Award to Davie Waggett, NCAP's incoming president.

Mark Gregory receives the Bristol-Myers Squibb Pharmacy Leadership Award from Fred Eckel.

W. Whitaker Moose, Sr. presents the National Community Pharmacists Association Pharmacy Leadership Award to Davie Waggett.

Rite of Roses Ceremony: NCAP Past President Jack Watts reads the names of members who have died since the last Convention as his wife, Eloise, places roses in a vase in honor of their memory.

Kim Leadon (center) presented the UNC School of Pharmacy Hospital Preceptor of the Year award to Vickie McLean and the UNC Community Preceptor of the Year Award to Kent Tapscott.

LeAnne Kennedy receives the Campbell University Preceptor of the Year Award from Valerie Clinard.

ice Forum Meeting March 6-9, 2005 in RTP, NC.

Sound-alike, Look-alike Medications

by Jim Hasspacher

JCAHO Makes Sound-alike, Look-alike Drugs a National Patient Safety Goal for 2005

For 2005, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has made sound-alike/look-alike drugs a National Patient Safety Goal for "critical access hospitals, hospitals, office-based surgery, ambulatory care, assisted living, behavioral healthcare, disease specific care, home care and long-term care organizations." JCAHO uses this text in the goal: *"National Patient Safety Goal- Identify and, at a minimum, annually review a list of look- alike/ sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs."*[1] In addition, JCAHO spells out exactly which drug combinations must be reviewed by organizations. A minimum of 10 drug pairs should be chosen from one set of tables and five other drug pairs from another set of tables provided by JCAHO. These tables, along with a description of the potential error, consequences and specific safety strategies, may be found on the JCAHO website at http://www.jcaho.org/accredited+organizations/patient+safety/05+npsg/lasa.pdf

Other resources for strategies to reduce error due to sound-alike/look-alike medications are also available.

- In addition to the JCAHO information, there are four comprehensive reviews that have been published on this topic.[2,3,4,5]
- The Institute for Safe Medicine Practice (ISMP) is always an important source for adverse drug event (ADE) information. Sound-alike/look-alike topics have appeared in their newsletter on numerous occasions.
- Individual adverse drug event reports specific to your practice site are also an important source of information.

Moses Cone Health System Approach to Reducing Errors from Sound-alike, Look-alike Medications

In addition to these resources, consulting other organizations' action plans for reducing error from sound-alike/look-alike medications may be useful in planning your own policy/action plans. At MCHS, we are adopting a multifaceted approach to decreasing these errors.

Policy Development

MCHS has adopted a specific written policy to implement a program that will address error reduction methods associated with sound-alike/look-alike medications. A safety team has been assigned to have regular meetings and agree on specific targeted drugs and strategies.

Automated Dispensing Machine Nomenclature and Tall Man Lettering

Automated dispensing machines (ADM) and floor stock are sources of error for sound-alike/look-alike medications. Having ADMs interface with medication profiles results in a lowered chance for sound-alike/look-alike errors. The ADM "profile" feature checks the medication being withdrawn from the machine and matches it to the clinical documentation system medication profile. If no match is found, the user must perform an "override" to retrieve the medication. MCHS currently has partial implementation of the "profile" interface feature. Our approach has been a review of the nomenclature for sound-alike/look-alike products and subsequent modifications. Modifications include adding the trade name in parentheses after the generic name, adding a separate entry for the trade name, inventory reduction and the use of tall man lettering when appropriate. Specific attention was paid to drugs that had multiple products starting with the same name (e.g. oxycodone based drugs and combinations) and sustained release drugs. Future changes that will lower risk involve adding "profile" technology to the entire system.

Tall Man Lettering and Clinical Advisories Associated with Smart Infusion Pumps

To prevent selection of the wrong intravenous drug infusion entry in the smart infusion pump, MCHS has used two approaches - tall man lettering and clinical advisory warnings when multiple concentrations of the same drug are present in the pump library.

Clinical Information System Alerts/Warnings

Automated pop-up warning screens are programmed into the MCHS clinical information system to warn clinicians about sound-alike/look-alike combinations that have previously resulted in ADEs or that have been reported in the literature. Examples include Haemophilus Influenzae Vaccine vs. Influenza Virus Vaccine and Sulfadiazine vs Sulfasalazine.

Use of a Warning Label at the Medication Storage Site

MCHS has adopted a warning label that can be placed at the location storage site of common sound/look-alike drug combinations. The label is made in two sizes – one to fit on unit dose medication bins and a larger version to place at sites where storage bins are larger.

Storage Location Modification

ADE's can be made by selecting the wrong product from a storage location site. In addition to adding the warning label to the storage location, plans should be made to move sound-alike/look-alike products that are especially error prone. Examples are Nitroglycerin 250mg premixed IV and Sterile Water 250ml, D5W 250ml Glass Containers and Heparin pre-mix and ciprofloxacin pre-mix IV medication infusion bags.

Use of Providing Drug Indication on the Written Prescription

The literature suggests to us that risk declines for ADEs related to sound-alike/look-alike medications when the physician specifies the indication of the drug on the written prescription. This may become a reality when systems are available that use automated prescription selection and transmittal and have fields that communicate drug indication. CPOE (computerized physician order entry) may be a way to automate this process as well. For now, encouraging physicians to write drug indication on the written medication order may be a worthy approach. MCHS has explored the idea of adding indication to the clinical information system drug record for specific situations.

Conclusion

Awareness of patient safety has prompted JCAHO to mandate National Patient Safety Goals for accredited organizations. Sound-alike/look-alike medications have been added to these goals for 2005. Resources are available for organizations seeking to reduce error due to sound-alike/look-alike drug combinations. Each organization should review current literature and self-experience to develop an approach to medication error reduction. ❖

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5. Aronson, J. Confusion over similar drug names problems and solutions. *Drug Safety*; 12(3):155-160, 1995.

About the Author...

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Update On North Carolina Community Pharmacy Residencies

The increasing number of new treatment modalities, expanding prescription volumes, and shrinking reimbursement rates have placed a large strain on pharmacists practicing in the community setting. In addition to these escalating demands on pharmacists, an increased importance has been placed on providing care that is more patient-centered. To meet these strains, community pharmacists must create new and innovative services that can help improve patient care and at the same time, advance the profession of pharmacy.

by James Bowman

To help pharmacists meet these demands, the American Pharmacists Association (APhA) started the Community Pharmacy Residency Program (CPRP) in 1986.[1] The CPRP was established as a means to provide formal postgraduate training that teaches pharmacists to develop new and innovative patient service ideas. Community Pharmacy Residents have many opportunities to improve their professional and clinical skills to help reach these goals. Resident activities include lecturing students, providing continuing education programs to health care professionals, providing direct patient care, and developing clinical services. Table 1 lists some tasks residents are currently addressing.

Pharmacy Resident James Bowman, PharmD.

TABLE 1. Current tasks performed by Community Pharmacy Residents	
• Administering Immunizations	• Teaching at Universities
• Conducting Health Fairs	• Developing Collaborative Practices
• Providing Hypertension Mgmt.	• Providing Primary Care in Indigent Health Clinics
• Long-Term Care Consulting	• Participating in Local and National Conventions/
• Compounding Medications	• Professional Meetings
• Working with Employers	

The American Society of Health-System Pharmacists (ASHP) and APhA provide joint accreditation for CPRP's. Each CPRP is usually affiliated with a School/College of Pharmacy. Also, many accredited residencies offer multiple practice sites. The most current numbers for Community Pharmacy Residency Programs are listed in Table 2.1

TABLE 2.	Residency Programs (CPRP)	Residency Sites (CPR)
Accredited	31	70
Waiting Approval	5	8
Non-Accredited	28	44
Total	64	122
* 35 states + the District of Columbia have CPRPs		

The number of CPRP's in each state varies widely across the nation, but the Southeast offers a disproportionately high number of these programs. There are eight sites in Tennessee, seven in Virginia, five in Georgia and one in South Carolina.[2] North Carolina has eight CPR sites, with The University of North Carolina at Chapel Hill (UNC-CH) School of Pharmacy and the Campbell University School of Pharmacy each offering four sites. UNC-CH will add a fifth site for the 2005-06 year. The North Carolina CPRP's have produced more than 20 graduates since their inception in 2000. The North Carolina CPRP sites are listed in Table 3.

TABLE 3.	UNC-CHAPEL HILL	CAMPBELL UNIVERSITY
Retail Chain Pharmacies	Kerr Health Care Center-Chapel Hill Kerr Health Care Center-Raleigh Kerr Health Care Center-Zebulon	Kerr Health Care Center-Benson Kerr Health Care Center-Asheville
Independent Pharmacies	Moose Professional Pharmacy-Concord Area LAHEC- Rocky Mount (Futrell Pharmacy Services-Jackson, McDowell's Pharmacy-Scotland Neck)	Ward Drug Co.-Nashville Central Pharmacy-Durham
*City listed is the primary location for each CPR site.		

Residents in an independent pharmacy setting may be exposed to more business training and compounding services, whereas those in a chain pharmacy may be exposed to more screening clinic and outreach programs. In addition, a resident may go outside the pharmacy for elective experiences to gain more comprehensive training in multiple areas (e.g., marketing in the pharmaceutical industry, drug information, professional association management, etc.). Graduates of our state's CPRP's have gone on to careers as faculty members, clinical coordinators, consultant pharmacists, and community-based clinicians. Others have worked towards store ownership.

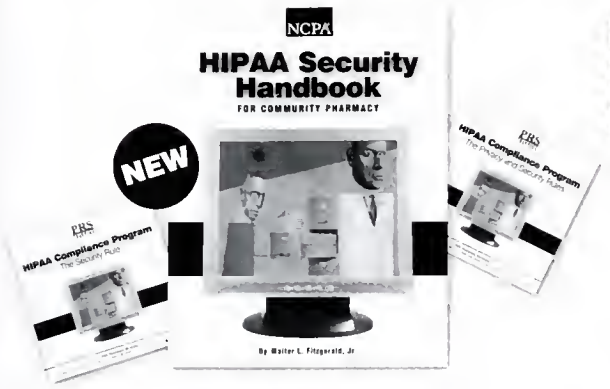
A key issue to consider when applying to a CPRP is the lower salary rate. The stipends for residents come from multiple sources, including grants, the pharmacy site, and the affiliated university. On average, each CPRP offers a salary usually ranging from $30-35,000.[2] Benefits associated with the residency are excellent and include health insurance and reimbursement for most professional activities including travel, professional memberships, and conventions. Together, the salary and benefits make a residency financially feasible for those who are considering a progressive community pharmacy career path.

When I decided to do a residency, I considered the lower salary, locations of available residency sites, and the current situation of loved ones in my family. The benefits I had to gain were expanded career possibilities, increased networking opportunities, and improved professional skills, to name a few. A key question that helped guide my decision to do a residency was, "What do I want to do with my career?" One thing that was emphasized to me during pharmacy school was that becoming a pharmacist is more than accepting a job, it's engaging in a life-long career. With a passion for taking community pharmacy to the next step, and a desire for entrepreneurship, I wanted to enter a CPRP in order to give myself the experience and skills to achieve these goals. After a couple of months in my residency, I felt that it was the best decision for me. In my opinion, a year of sacrifice makes for a life-long career of happiness.❖

References.
1. Phone Interview. Anne L. Burns, APhA Community Pharmacy Residency Program, Department of Practice Development. Interviewed Sept 7, 2004
2. http://www.aphanet.org. American Pharmacists Association (APhA). Accessed Sept 7, 2004

About the Author...
James M. Bowman, PharmD, is a Community Pharmacy Resident at Moose Pharmacy in Concord, NC.

HIPAA security rule **deadline**



April 20, 2005, the Security Rule portion of HIPAA becomes law. Unlike the Privacy Rule, which became enforceable April 14, 2003, the Security Rule takes place behind the scenes and regulates your pharmacy operations, computer systems, and electronic information. The Security Rule is predicted to require more time to implement than the Privacy Rule, so don't delay. A Risk Analysis and a Disaster Recovery Plan are mandated under the Security Rule—**Are you ready?**

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Precepting Duke Medical Students at Kerr Drug

by Janell Norris Downing

On August 18th Kerr Drug began a new relationship with the Duke University School of Medicine. The relationship is based on a new program, Intersessions, which consists of half-day visits from second-year medical students. The goal of the program is to give medical students the opportunity to meet with non-MD professionals in various settings in the medical community, and to learn about the services and therapies offered in these areas.

In preparation for the visit, I was presented with a list of core objectives to be achieved upon completion of the Pharmacy Intersession. The following objectives were used in planning the pharmacy experience:

- Describe the nature of the health care team member's work and interaction with patients.
- Describe the major stresses for health care team members inherent in this work or setting.
- Observe and describe the nature and quality of the interactions, verbal or written, between the health care team member and physicians.
- Describe how the services given by this provider are paid for and whether timely reimbursement is an issue.

The medical student visit consisted of two students visiting for four hours in the morning, and two more students visiting for four hours in the afternoon. The experience began with a half-hour orientation to the Kerr Health Care Center and Kerr Drug dispensing pharmacy. During the orientation the students' knowledge and perceptions of community pharmacy were assessed and areas of needed education were identified.

(front to back) Pharmacy Technician and 3rd year UNC pharmacy student Michael Teaster, Pharmacy Technician and 1st year UNC pharmacy student Lisa Adams, Duke medical student Ryan Turley, Community Pharmacy Resident Joe Heidrick.

One student spent an hour and a half in the dispensing pharmacy while the other student spent the respective amount of time in the Center. In the dispensing pharmacy the student participated in the filling process from drop-off or call-in to pick-up. The students were precepted in the morning by Joe Heidrick, PharmD, and in the afternoon by pharmacy manager Chris Bowen, RPh. The pharmacist presented requirements of a valid prescription, proper transcription of prescriptions recorded on the physician message line, verification of illegible or questionable prescriptions, and allowed the students to contact physician offices to request prescription refills. The student observed the pharmacist counseling patients on prescription and OTC medication and participated in hands-on product recommendation in the OTC aisles.

Some stresses of the everyday pharmacy were presented and included the following: insurance billing issues, computer inefficiency, high script volume with little time for patient counseling, no reimbursement for time spent with patient, and patient dissatisfaction with long wait times or medications not in stock due to tightly controlled inventory.

For the next hour and a half the medical students switched places between the Center and the pharmacy. I presented the Kerr Health Care Center to the student as a new and innovative practice area for community pharmacy. The community residency was reviewed as a requirement for the position of Clinical Coordinator in the Health Care Center. Students were able to interact with resident Joe Heidrick and observe the responsibilities and intense education involved in the residency year.

All of the services and screenings provided in the Center were discussed with the students and included: blood pressure, cholesterol, blood glucose, bone density, TSH, PSA, ankle brachial index screening, blood glucose meter training, medication management, and disease-state management. Another important service presented was the administration of the flu vaccine by certified pharmacists beginning this flu season. Students were shown examples of pharmacist collaboration with physicians to manage diseases and medications, and the benefits of medication and disease state management were discussed. Limitations of the health care center model, such as reimbursement limited to cash due to no insurance coverage of these services, were presented along with the possibility to make improvements in this area with the new Medicare Act.

During the last half-hour of the Pharmacy Intersession I met with the students to discuss the learning experience. I asked the students to relay back to me what they had learned and what they felt was most beneficial about this experience. The comments I received from the students were very positive and revealed a great improvement in knowledge and perception from the initial assessment in the first half-hour orientation. Through the following comment, provided by second-year medical student Christopher Woo, it was revealed to me that my goals for the experience had been met: "I realize now that pharmacists play a more expansive role in providing health care to the patient. They check to ensure that prescriptions are filled accurately and are relevant to the patient, and also help in medication management, a role that is increasing in importance given the aging population and increasing number of medications patients are on. In addition, Kerr's business model further extends the role of pharmacists to help clinically manage chronic conditions such as hypertension, diabetes, and hyperlipidemia in a proactive manner. This helps to fill the gap between physician visits, and also provides valuable information that the patient can bring to the physician to allow the physician to provide more relevant care." ❖

About the Author...

Janell Norris Downing PharmD, is Clinical Coordinator at Kerr Health Care Center in Chapel Hill. She can be reached at jdowning@kerrdrug.com

Another Opportunity to Advance NC Pharmacy

A New Challenge: The NCAP Building Remodeling Fund

NCAP has successfully matched a $100,000 challenge grant from the Pharmacy Network Foundation to establish a Building Endowment Fund of $200,000. This fund assures that the Institute of Pharmacy building is preserved with endowed funds that can be used in the future for maintenance and upkeep. However, our building is in need of repair and refurbishing right now so the Pharmacy Network Foundation has provided another challenge to NCAP members. They have pledged to match contributions to the Building Remodeling Fund on a two-to-one basis, up to a total contribution of $50,00 each year for the next two years (2005 and 2006). If we meet their challenge we'll have $150,000 to refurbish and repair our building now. Past President Jack Watts continues to chair this fundraising effort. Your contributions made this year are tax-deductible but will count towards the 2005 challenge so please say *"Yes I can help preserve the Institute of Phamnacy."*

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My pledge to the NCAP Endowment Fund is:

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The Pharmacist Refresher course is designed for pharmacists who wish to return to community pharmacy practice after an absence from practice for three or more years. The course consists of three modules, all of which have been approved for American Council on Pharmaceutical Education (ACPE) continuing education credits. The first two modules are completely online and composed of weekly study segments that allow course participants to work at their own pace, on their own time. The third module consists of a three-week, 90-hour 'live' experience in a community pharmacy. The Connecticut Pharmacy Association (CPA) will assist in sourcing pharmacies at which participants can complete the module. Only those who participate in all three modules will earn a Pharmacist Refresher Course Certificate from Charter Oak State College. Those taking modules One and/or Two for personal enrichment will earn ACPE credits through CPA.

Module One: $500

This web-based module addresses the most commonly prescribed drugs, the most commonly used over-the-counter (OTC) medications, nutritional supplements, and herbal products. Focus is on the "Top 200" drugs and the disease states for which they are used. This module is accessible for eight weeks and should take approximately 50 hours to complete Upon completion of the module the participant will be able to:

- Identify the most commonly dispensed brand and generic drugs (often referred to as the "Top 200").
- State for each drug, their indications for use, contraindications, and common and significant drug-drug interactions (including OTC's and nutritional supplements).
- List for each drug, their usual dose, dosage forms and propensity for causing allergic reactions and side effects.
- Explain to patients the proper use of each of the Top 200 Drugs.
- Explain and compare the cost of therapy for the various drugs in each therapeutic category.
- List and discuss the traditional therapeutic categories of OTCs.
- List and discuss the common ailments amenable to treatment with OTCs.
- Identify the limitations of self care/medication.
- Identify and be able to recommend products within each category given patient specific information.
- Identify potential drug-drug interactions between OTCs and Rx medications.
- Identify and be able to assess the various types of alternative therapies/treatments.
- Compare appropriate use of vitamins, minerals, and nutritional products.
- Explain the Rx to OTC Switch process including future candidates for "switch."
- Explain brand/line extensions and impact on consumers and pharmacies.
- Explain the concept of a third class of drug.

ACPE#: 106-000-03-015-H01 (50 contact hours*)
*These contact hours are considered home study, not live.

Module Two: $500

Also web-based, this module addresses pharmacy law, third party issues, and prescription processing with a focus on safe prescription practices. Module Two is accessible for a six-week period and should take approximately 45 hours to complete. Upon completion of the module the participant will be able to:

- Explain all laws pertaining to prescription processing of non-controlled and controlled substances and the record-keeping for those substances.
- Compare laws pertaining to pharmacists' supervision of interns, technicians and temporary pharmacists. Identify the duties and limitations of the technicians.
- Discuss the ethics of filling prescriptions and confidentiality.
- Explain Medicare, Medicaid, Pharmacy Benefit Managers and cash discount programs.
- Explain deductibles, co-payments, maximum benefits, tiered benefits, and formulary lists.
- Identify documentation, counseling and record keeping requirements.
- Identify Product Selection Codes (aka Dispense As Written codes) and NCPDP formats.
- Explain prior authorizations, step therapies and other reject messages.
- Compare audit types and payment adjustments.
- Compare new and refill prescription requirements.
- Identify the various transmission methods of a prescription to a pharmacy and the regulations concerning those methods.
- Explain ways to perform prospective, concurrent, and retrospective drug utilization reviews.
- Explain the OBRA counseling requirements.
- Identify ways to maintain the prescription in a manner that satisfies legal and third party requirements.
- Identify a quality assurance program for error prevention and reporting.

ACPE#: 106-000-03-016—H03 (15 contact hours Law*) ACPE#: 106-000-03-017-H04 (30 contact hours*)

Module Three: $500

This module is a supervised, three-week, ninety contact hour, hands-on practicum in a community pharmacy. The participant will incorporate knowledge acquired from Modules One and Two with experience gained from Module Three to provide effective counseling and safe dispensing practices. A current pharmacist license, professional liability insurance and health and disability insurance are required to participate in Module Three. (90 contact hours) Upon completion of this module the participant will be able to:

- Design a personal quality assurance plan that will ensure safe prescription practices.
- Explain to a patient the proper use of their prescription at the time of dispensing.
- Select the appropriate OTC product for a patient and counsel them on its use.
- Identify methods to incorporate proper legal documentation in the filling and record keeping of prescription drug processing.
- Demonstrate competence in third party issues with regard to billing, record keeping and prescription processing.
- Demonstrate proficiency in defined competencies of the various aspects of pharmacy practice.

ACPE#: 106-000-03-018-L04 (15 live contact hours)

Payment by cash, check, or credit card (Visa, MasterCard, Discover). A payment plan is also available.

ACPE The Connecticut Pharmacists Association is accredited by The American Council on Pharmaceutical Education as a provider of continuing education

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To find out when the next Pharmacist Refresher course begins, or to register, call Charter Oak's Distance Learning Office at (860) 832-3837 or (860) 832-3812 or visit http://www.cosc.edu/distancelearning/noncredit.cfm. For additional information about course content, contact the Connecticut Pharmacists Association at (860) 563-4619.

Small Doses

Second-year W.U. pharmacy student Kevin Allen presents a white coat to Kara Beth Haynes.
Photo courtesy of *The Enquirer Journal*

Wingate University Holds White Coat Ceremony

The Wingate University School of Pharmacy officially welcomed its second class of 60 pharmacy students during a White Coat Ceremony on Aug. 22, bringing the school's total enrollment to 120.

Pharmacy students from the school's charter class presented each student with a white coat, also known as a consultation jacket, as a symbolic initiation into the school as a future pharmacist.

Dr. Bruce Canaday of the UNC School of Pharmacy and Medicine, delivered a message to the students on how failures can be opportunities to learn and grow.

According to Wingate University President Jerry McGee, the School of Pharmacy has gained significant recognition since it opened its doors in 2003. More than 250 students applied to the school during its first year and more than 700 the second year.

James Named Independent Pharmacist of the Year

NCAP member F. Michael James, RPh, has been named the 2004 Willard B. Simmons Independent Pharmacist of the Year by the National Community Pharmacists Association (NCPA). The announcement was made during the association's 106th Annual Convention in Boston, MA.

The Independent Pharmacist of the Year Award, sponsored by Roche, recognizes an independent pharmacist for exemplary leadership and commitment to independent pharmacy and to the community. The award is named in honor of Willard Simmons, a former NCPA (then NARD) executive secretary, and long-time NCPA Foundation Trustee.

James is director of governmental affairs for the Association of Community Pharmacists in North Carolina, as well as Mutual Wholesale Drug Co. He is also the owner of three community pharmacies in North Carolina.

He currently serves as chairman of the board for the North Carolina Retail Merchants Association. He has served on the North Carolina State Health Coordinating Commission, State Medicaid Board, and the North Carolina State Banking Commission.

An active member of NCPA, James has served on the association's Committee on National Legislation and Government Affairs for several years, and served as its co-chairman in 2003. James was named North Carolina Pharmacist of the Year in 2003.

As the recipient of the award, James received an engraved plaque, a $1,000 cash award, and a $1,000 donation in his name to the Campbell University School of Pharmacy.

Dave Moody, CEO of NC Mutual Drug, and Mike James, NCPA Pharmacist of the Year, at the North Carolina Pharmacy Leaders Forum held in August at the Grandover Resort near Greensboro. The Forum is sponsored by the NC Board of Pharmacy.

2005 Pharmacy Technician Certification Board Exam Dates

App. Processing Begins	Application Deadline	Withdrawal Deadline	Examination Date
Nov. 23, 2004	Jan. 21, 2005	Feb. 18, 2005	**March 19, 2005**
March 29, 2005	May 27, 2005	June 24, 2005	**July 23, 2005**
July 26, 2005	Sept. 23, 2005	Oct. 21, 2005	**Nov. 19, 2005**

Technicians interested in becoming nationally certified should contact PTCB at ptcb.org or (800) 363-8012 to register for the PTCB Exam. **To make sure you're fully prepared for the PTCB Exam, sign up for one of NCAP's Technician Exam Review Seminars. Dates and locations for the Review Seminars will be announced soon.**

"REACH ONE FOR NCAP"

NCAP Membership Campaign

NCAP is seeking the help of its members to increase membership in the Association. Please encourage a friend or a co-worker who is not a member to join. Sponsorship will earn you an entry in a drawing for a free 1-yr NCAP membership (drawing to be held at the 2005 Convention). Your primary reward will be the satisfaction you receive from seeing your Association grow.

HELP OUT - "REACH ONE FOR NCAP"

North Carolina Association of Pharmacists Membership Form, 2005

Full Name: _____ **Degree:** _____ **DOB:** _____

Title: _____ **Business Name:** _____

Work Address: _____

_____

Work Phone: _____ **Preferred Fax:** _____

College: _____ **Class Year:** _____ **NC Pharmacist License#:** _____

Home Address: _____

_____

Home Phone: _____ **Preferred E-mail:** _____

Sponsor's name:

☐ **PLEASE CHECK BOX IF YOU WANT A CERTIFICATE OF MEMBERSHIP FOR DISPLAY (8 1/2 BY 11)**

Preferred (Mailing Address): _____ **Home** _____ **Work**

MEMBERSHIP CATEGORIES: (Circle One)

Active Pharmacist: $175.00 **Associate** (non-pharmacist): $175.00 **Joint** (both husband & wife): $270.00 **Retired Pharmacist:** $95.00
Resident/Fellow: $95.00 **Out of State:** $95.00 **New Graduate** (2004): $50.00 **Pharmacy Technician:** $35.00 **Student:** $10.00

All membership dues include membership in a primary Practice Forum: (Circle One)

Acute Care (Hospital) **Technician** **Ambulatory Care** (Community) **Chronic Care** (Long-Term)

NCAP President's Club: I wish to support NCAP by making a tax-deductible contribution to the NCPhA Endowment Fund.
(Platinum Member-$1,000.00+ Gold Member-$100.00+ Silver Member-up to $99.00)

Payment Information: (check one): Check Enclosed _____ MC _____ Visa _____

Card Number: _____ Expiration Date: _____

Signature: _____ Date: _____

*Membership Dues: $_____
Contribution to President's Club: $_____
Total Enclosed: $_____

If you're using a credit card, please fax this form to (919) 968-9430. If you have any questions please call: (919) 967-2237 / (800) 852-7343
Otherwise, please mail the form and your check to: NCAP, 109 Church Street, Chapel Hill, NC 27516

Please visit us at www.ncpharmacists.org

If you would like to join the Local Association in your area you can find a complete list under the Governance tab.

*12% of your membership dues are non deductible for Federal income tax purposes due to lobbying activities conducted by the association on behalf of its members.